

SUMMARY OF DOLE/PACKWOOD HEALTH REFORM PROPOSAL

I. GUARANTEED ACCESS TO COVERAGE

A. Insurance Reforms

1. There are two health insurance market sectors:
 - a. Individuals and small employers size 1 to 50.
 - b. Large groups (employers with more than 50 employees or members, and associations and MEWAs with at least 500 participants).

2. The insurance market reforms apply to all health plans, including self-insured plans, with the following exceptions:
 - a. Accident, dental, vision, disability income, or long-term care insurance;
 - b. Medicare supplemental policies;
 - c. Supplements to liability insurance;
 - d. Workers compensation insurance;
 - e. Automobile medical-payment insurance;
 - f. Specific disease or illness policies; or
 - g. Hospital or fixed indemnity policies.

3. Guaranteed issue and guaranteed renewal.
 - a. A health plan may not deny, limit, condition, or refuse to renew a health benefit plan except as indicated in (c) below.
 - b. A self-funded health plan sponsored by an employer cannot deny, limit, condition, or refuse to renew coverage for any employee (and family) except as indicated in (c) below.
 - c. Exceptions:
 - i. Pre-existing condition limitations can be imposed on individuals who do not maintain continuous coverage as described in (4) below.
 - ii. Failure to pay premiums;
 - iii. Misrepresentation of information to the insurer, or fraud;
 - iv. The health plan doesn't serve the area;
 - v. The health plan withdraws the health benefit plan from the market entirely.
 - vi. The health plan does not serve the market sector to which the person or group belongs.
 - vii. The health plan has insufficient capacity to enroll new members.

- d. A health plan that has approached its capacity limitations can refuse to accept new enrollment, or limit enrollment based on a first-come, first-served basis.
- e. Individuals will have an annual open enrollment period of at least 30 days prior to the expiration of their health plan policy, during which individuals can change health plans without being subject to pre-existing condition exclusions. Individuals can make changes between open enrollment periods for certain qualifying events like changes in family status, employment, residence, etc.
- f. Newborns are covered automatically on the parent's policy at birth.
- g. Insurers or employers cannot impose waiting periods for coverage beyond a reasonable time necessary to process enrollment, except in accordance with the standards for pre-existing condition exclusions described in section 4 below.

4. Portability and Pre-existing Conditions

- a. Health plans may not impose pre-existing condition limitations on individuals enrolling as a member of a group, except in cases where the individual has not been insured during the previous 6 month period.
 - i. The maximum allowed pre-existing condition exclusion for a condition diagnosed or treated during the 3 months prior to coverage is 6 months.
 - ii. The maximum is reduced by one month for every month the individual had coverage during the preceding 6 month period.
- b. Health plans may not impose pre-existing condition limitations on individuals who are not enrolling as a member of a group, except in cases where the individual has not been insured during the previous 12 month period.
 - i. The maximum allowed pre-existing condition exclusion for a condition diagnosed or treated during the 6 months prior to coverage is 12 months.
 - ii. The maximum is reduced by one month for every month the individual had coverage during the preceding 12 month period.
- c. Amnesty period.
 - i. Each state will set an initial 90 day open enrollment period during which individuals who have not previously had health benefit coverage can enroll without being subject to pre-existing condition limitations.

- ii. A state may establish a limit on the number of new enrollees a health plan must accept during the amnesty open enrollment period. The limit should correspond proportionately to the total number of enrollees the plan has in that market sector. ✓
5. Modified community rating (applies to all products in the individual and small group market only).
- a. Uniform age and family classes will be defined by the National Association of Insurance Commissioners (NAIC).
 - b. NAIC will recommend allowed discounts for health promoting activities.
 - c. The ratio of rates between the highest and lowest age factor (ages 18-64) may not exceed 4:1 for the first 3 years after implementation, and 3:1 for years thereafter.
 - d. NAIC to recommend allowed variations in administrative costs (not to exceed 15 percent of premium) based on size of group.
 - e. States will define community rating areas subject to the following:
 - i. Minimum area population of 250,000.
 - ii. May not divide metropolitan statistical areas within a state.
 - iii. May cross state boundaries if states agree.
6. Every health plan selling in the individual and small group market sector must offer the FedMed package.
- a. An insurer must at least offer one of the following versions of the FedMed package:
 - i. Fee-for-service,
 - ii. Preferred Provider Organization (PPO), or
 - iii. Health maintenance organization (HMO).
 - X b. Health plans may offer any other health benefits packages in addition to the FedMed package.
 - c. Health plans may offer supplemental packages to the FedMed package, but may not require an individual or a group to purchase supplemental coverage or link the pricing of a supplemental benefit package to that of the standard package.
- X 7. There is no restriction on the number of different benefit packages that can be offered by a health plan. However, the rates for all of the health benefit packages offered by the health plan must be based on the health plan's total enrollment in the individual and small group sector. Rating variations are allowed only to the extent of the difference in actuarial value of the specific benefit variations for that same population. X

8. Health plans and purchasing cooperatives may require payment of premiums through payroll deductions. Employers must comply with employee request for payroll deduction and remittance of premium.
9. Risk adjustment (applies to the individual and small employer market only.) States are to risk adjust community-rated health plans and reinsurers of health plans for small employers who self-insure. All self-insured small employers are required to carry "stop-loss" insurance.
10. Standards developed by the NAIC for the individual and small group market shall be uniform for all carriers.
11. Each state will publish annually and disseminate a list of all of the health plans in the state offering the FedMed package and their modified community rate for the package. This effort will be coordinated with the information on health plan quality.
12. Neither the states nor purchasing groups would be permitted to interfere with the ability of health insurers to establish and pay adequate compensation to licensed agents and brokers.
13. Taft-Hartley health plans, rural electric and telephone cooperative health plans and church association health plans shall be subject to the insurance reforms applicable to large employer plans.

B. Purchasing Cooperatives, FEHBP, MENAs and Association Plans

1. Nothing in this bill requires the establishment of a purchasing group -- nor prohibits the establishment of more than one --in an area.
2. Purchasing groups established to serve the individual and small employer market must be open to all individuals and small employers who wish to join.
3. Any health plan offering a benefit package through a purchasing cooperative must offer at least the FedMed benefit package through the cooperative.
4. Insurers are prohibited from establishing a purchasing cooperative but may administer one under contract with the purchasing cooperative.

5. Federal Employees Health Benefit Plan

- a. Self-employed individuals and small employers (size 2 to 50) may purchase health benefit plans offered through FEHB program.
- b. Insurers shall offer self-employed individuals and small employers the same benefit plan(s) that are available to federal employees at the same premium price (government and employee share) plus an administrative fee.
- c. Health plans may impose group participation requirements as long as they are standard for all groups.

6. MEWA and Association Health Plans

Limited rules are applied to existing MEWAs and Association health plan offering health plans on 1-1-94 (i.e. "Grandfathered plans") and a more comprehensive regulatory scheme is applied to all new MEWAs and association plans. Grandfathered plans and all new plans that meet the following rules shall be treated as a large employer for insurance reform purposes.

- a. Grandfathered plans (both insured and self-insured) must have at least 500 participants. In addition, grandfathered plans cannot:
 - i. Condition its membership on health status or health claims experience of a potential member.
 - ii. Exclude an employee or dependent of a member based on their health status.
- b. Grandfathered plans that self-insure must:
 - i. File written notification with the Secretary of Labor that:
 - (1) includes a description of the plan; and,
 - (2) names a plan sponsor.
 - ii. Meet minimum financial solvency and cash reserve requirements for claims established by the Secretary of Labor.
 - iii. File annual funding reports (certified by an independent actuary) and financial statements with the Secretary of Labor and all participating employers in the plan.
 - iv. Appoint a plan sponsor that would be responsible for operating the plan and seeing that it complies with all federal and state laws.
- c. All new MEWAs and association health plans must:
 - i. Cover at least 500 participants.
 - ii. Complete a certification procedure established by the Secretary of Labor.
 - iii. Meet all the requirements in 6.a. and if self-insured, meet the additional requirements in 6.b.ii. through iv. above.

- iv. Be formed and maintained for substantial purposes other than obtaining or providing health insurance to members.
 - v. Be offered or sponsored by a permanent entity which receives a substantial majority of its financial support from its active members.
 - vi. Not be owned or controlled by an insurance carrier.
 - vii. Has a constitution, bylaws, mission statement or other similar governing documents.
 - viii. All persons involved in operating, administering and/or handling money with respect to plan would have to be bonded for theft and other intentional acts.
 - ix. Pay a \$5,000 certification fee to the Secretary of Labor. The Secretary may also charge a reasonable annual fee to cover the cost of processing and reviewing annual filings.
- d. The Secretary of Labor shall develop regulations implementing the requirements of this section including expedited registration, certification, review and comment procedures.
 - e. The Secretary may enter into agreements with states to enforce the provisions of the section to the extent that the delegation does not result in a lower level or quality of enforcement. Such delegation may include certification and registration of MEWAs and association plans.
 - f. Associations and MEWAs must provide written notice to each contributing employer as to whether it has met the applicable requirements of this section 6.
 - g. All individuals operating or administering or involved in the financial affairs of association health plans or MEWAs must be bonded.
 - h. Taft-Hartley health plans, rural electric and telephone cooperative health plans with 500 or more participants and church association health plans with 100 or more participants are exempt from all requirements described in section 6 and are subject to the insurance rules applicable to large employer plans.

C. Affordable Coverage

1. Tax Deduction for Self-Employed

Self-employed individuals and other individuals who do not get health insurance from their employers would get a deduction equal to 100 percent of the cost of insurance phased in as follows:

1994 and 1995 -- 25% 1998 and 1999 -- 75%
1996 and 1997 -- 50% 2000 and after -- 100%

2. Medical Savings Accounts

- a. Medical savings accounts (MSAs) are linked with the purchase of catastrophic health insurance coverage (health insurance policy with a minimum \$1,000 annual deductible for single, and \$2,000 for family coverage).
- X b. Employer contributions to MSAs are excludable from an employee's income and not subject to payroll taxes. Employer can deduct its contributions.
- c. Contributions by self-employed and individuals (whose employers do not provide employer-subsidized insurance) are deductible from income and excludable from payroll taxes.
- d. Annual limit on contributions--\$2000 single person and \$4000 for families (one account per family).
- e. No lifetime limit on amounts contributed.
- f. Distributions from the account would be tax-free and penalty-free if used for medical expenses not reimbursed under the catastrophic policy, premiums for catastrophic coverage during "COBRA" continuation coverage, and for premiums and medical expenses for long-term care. Premiums for catastrophic coverage cannot be paid out of MSA unless the individual qualifies for COBRA continuation coverage.
- g. MSAs subject to prohibited transaction, reporting and certain other rules applicable to IRAs.
- h. Tax-free rollovers between MSAs but not between MSAs and IRAs.
- i. Non-qualified withdrawals are taxable and subject to a 10 percent penalty.
- j. Not transferable at death and taxable to decedent.
- k. No tax-free build-up.
- l. Distributions on account of divorce to follow rules applicable to IRA's.

3. Low-income Subsidies

- a. Creates a new safety net subsidy program for low-income individuals and families not covered by employer-provided insurance or public programs. Subsidies would be financed by the Federal government consistent with the Budget Fail-Safe mechanism (described later).
- b. Subsidies would not be provided to:
 - i. Individuals/families who are not U.S. citizens or permanent resident aliens;
 - ii. Medicaid eligibles;
 - iii. Medicare beneficiaries; or

- iv. Individuals who receive employer-financed coverage.
- c. An employer that finances health care coverage for any employee would not be allowed to discriminate against any employee based on his/her eligibility for a low-income subsidy. Employers who violate this rule would be assessed a penalty equal to the maximum subsidy amount for the geographic area multiplied by the number of affected individuals.
- d. In the case of an employee working for an employer providing employee-only coverage (not including the employee's dependents) and whose family is otherwise eligible for a subsidy, the employee would have the option to take the employer's coverage or subsidized family coverage.
- e. Subsidies will be applied only to the purchase of the FedMed package defined by the Secretary of HHS. By regulations, the Secretary shall establish a FedMed benefits package that includes, at a minimum, the categories of benefits described in Title 5 of the United States Code for the Federal Employees Health Benefit program and in the HMO Act of 1973 (Section 1302(1) of the Public Health Service Act). In so doing, the Secretary shall take into account, the following priorities:
 - i. Parity (with respect to cost-sharing and duration of treatment) for mental health and substance abuse services, managed to ensure access to medically appropriate treatment and to encourage use of outpatient treatments to the greatest extent feasible;
 - ii. Consideration for needs of children and vulnerable populations, including those in rural, frontier, and underserved areas; and
 - iii. Improving the health of Americans through prevention.
- f. In general, health plans will determine the medical appropriateness of specific treatments. Coverage decisions about new procedures and technologies will be made by health plans, which may refer to criteria for medical appropriateness developed by the Secretary.
- g. The Secretary shall vary cost sharing arrangements to accommodate different delivery system models through which subsidized individuals may receive health care services. All versions of the FedMed package shall have reasonable cost-sharing (including an out-of-pocket limit) appropriate to the delivery system.
 - i. For a moderate cost sharing version, cost sharing shall be similar to the health plan in the Federal Employees Health Benefit

- program with the highest enrollment that uses a fee-for-service delivery system.
- ii. For a low cost sharing version, cost sharing shall be similar to the HMO plan in the FEHB program with the highest enrollment.
 - iii. For plans with provider networks, higher cost-sharing sufficient to encourage use of the network shall be allowed for out-of-network, nonemergency services.
- h. In defining the initial benefits package, the Secretary shall ensure that the actuarial value of the package in its fee-for-service version be equal to the actuarial value of the highest-enrollment plan offered under the Federal Employees Health Benefit program in 1994, assuming a national population under age 65. Managed care health plans shall offer the same set of services defined by the Secretary for fee-for-service health plans.
- i. Subsidies would be provided for premiums only, up to a maximum amount. The maximum subsidy amount would be the amount the Federal government uses to calculate its maximum (75%) contribution for Federal employees' insurance under FEHBP, calculated without the population 65 and older. The maximum amount would be determined annually. Nothing shall be construed as preventing an individual or family from buying a health plan covering the FedMed package that is more expensive than the maximum subsidy amount. The individual would have to pay the difference between the health plan's premium and the maximum subsidy amount.
- j. The Secretary of HHS will specify maximum subsidy amounts for each geographic market area for the same age groups and family composition classes in the small group market. The Secretary would use appropriate factors to adjust the maximum amount for:
 - i. Geographic differences in health care costs;
 - ii. Age; and,
 - iii. Family composition (there would be no poverty adjustment for family size greater than 4).
- k. Individuals and families with income below 100% of the Federal poverty level (if funding is available) would receive a full premium subsidy.
- l. If additional funding is available, individuals with income above the poverty level would receive a partial premium subsidy. Individuals above 150% of poverty would not be eligible for a subsidy.
- m. For individuals with income above the poverty level but below 150%, the subsidy percentage would

decline on a stepped basis as income increased. The amount of the subsidy would be a percentage of the maximum subsidy amount for individuals below poverty.

- n. Eligibility for subsidies will be calculated on an annual basis. Tax return information will be used in determining eligibility to the extent possible.
- o. An individual or family that has an approved application for a subsidy must file an end-of-year income reconciliation statement. Failure to do so will result in ineligibility for subsidies until the statement is filed, unless there is good cause.
- p. States would determine eligibility for subsidies. States will be liable to the Federal government for subsidy payments made in error. The Federal government would share the administrative expense of determining eligibility for subsidies at a rate of 50% Federal/50% state.
- q. States would designate appropriate agencies/organizations that would determine eligibility and enroll individuals in health plans on-site. States would be required to provide information on all health plans offering the FedMed benefit package in the geographic area.
- r. The Secretary of HHS will develop standards to assure consistency among states with respect to data processing systems, application forms, health plan information, and other necessary activities to promote the efficient administration of subsidies.
- s. The Secretary will study and make recommendations to the Congress regarding use of state-adjusted poverty level guidelines instead of the Federal poverty level guidelines when determining eligibility for subsidies.

D. Report on Health Care System

By January 15, 1998, the President must submit to the Congress findings and recommendations on each of the following:

1. Characteristics of the insured and uninsured, including demographic characteristics, working status, health status, and geographic distribution.
2. Steps to improve access to health care and increase health insurance coverage of the chronically uninsured.
3. Effectiveness of insurance reforms on access and costs.
4. Effectiveness of federal assessments of new technology on the cost and availability of new products.

5. Effectiveness of cost containment strategies at the federal and state level and in the private sector.
6. Effectiveness of efforts to measure and improve health care outcomes in the public and private sector.
7. Effectiveness of new federal subsidy programs, including recommendations to restrain future growth.
8. Effectiveness of initiatives targeted to underserved urban and rural populations.

II. IMPROVED HEALTH CARE DELIVERY SYSTEM

A. Consumer Value In Health Plans

1. A "Consumer Value" program will be developed by the states for the purposes of:
 - a. Assuring minimum quality standards for health plans;
 - b. Making available comparative information about health plan offerings; and
 - c. Establishing certain consumer protections.
2. The Secretary of Health and Human Services will assist the states in carrying out these activities by:
 - a. Consolidating research activities for quality and consumer information areas;
 - b. Developing minimum guidelines for use in certifying health plans in the areas of quality assurance, consumer information, consumer protections, and financial practices and performance; and
 - c. Requiring states to establish a consumer value program that results in comparative information on health plan offerings and quality distributed to all consumers.
 - d. Offering grants to states to set up the consumer value program.
3. Consolidating Research Functions for Quality and Consumer Information
 - a. Current federal research activities supporting quality and consumer information will be consolidated within HHS and called the Agency for Quality Assurance and Consumer Information. The agency will carry out its activities in close consultation with expert private and public entities in quality and consumer information. Research priorities will be set in consultation with expert groups.
 - b. The focus of the new consolidated research area will be to support activities in the areas of:

- i. Effectiveness and appropriateness of health care services and procedures;
 - ii. Quality management and improvement;
 - iii. Consumer information and surveys concerning access to care, use of health services, health outcomes, and patient satisfaction;
 - iv. Development, dissemination, applications, and evaluation of practice guidelines;
 - v. Conduct effectiveness trials in the private sector in partnership with expert groups;
 - vi. Assure the systematic evaluation of existing as well as new treatments and diagnostic technologies in a continuous effort to upgrade the knowledge base for clinical decision-making and policy choices;
 - vii. Recommend minimum guidelines for quality measures, consumer information categories, and access (to health services and practitioners) for use in health plan certification;
 - viii. Recommend standards and procedures for data and transactions related to quality, consumer information, access, effectiveness, and other areas as appropriate to assure a smooth coordination with the administrative simplification framework; and
 - ix. Oversee basic and applied research, with equal attention to each.
- c. Funding will be \$250 million a year by the year 2000 (phased in). Spending will be split to support research and the application of research in the private health care delivery system.

4. Process for Certification

- a. Secretary of HHS Responsibilities
 - i. The Secretary, in consultation with NAIC and expert groups in the areas of quality assurance (such as the Joint Commission on Accreditation of Healthcare Organizations, the National Committee for Quality Assurance, and the Peer Review Organizations) will set minimum guidelines for the certification of health plans. The Secretary is to complete the guidelines within 6 months of enactment of the bill.
 - ii. Special Federal rules would apply to self-insured multi-state employer plans and MEWAs.
 - iii. The Secretary will approve certifying organizations that are qualified to complete health plan certifications in any state.

- b. States' Responsibilities
 - i. States will be responsible for implementing the guidelines;
 - ii. States are expected to coordinate public health department and insurance commissioner offices' (and other relevant agencies) responsibilities in designing the certification process (and enforcement procedures);
 - iii. States shall consult with expert private entities in designing their certification and enforcement processes;
 - iv. States may contract with private entities (giving them deemed status) for carrying out the certification activities; and,
 - v. Health plans must absorb the costs of certification, however, the State and/or the Secretary may provide monies for technical assistance for health plans serving vulnerable populations to pay for certification or to assist these plans in preparing to be successfully certified.

5. Minimum Guidelines for Health Plan Certification

The Secretary of HHS will develop minimum guidelines for certification of health plans in these areas:

- a. Quality Assurance Guidelines
 - i. Quality management
 - ii. Credentialling
 - iii. Utilization management
 - iv. Governance
 - v. Policy and quality processes
 - vi. Provider selection and due process
 - vii. Guidelines and protocols
- b. Consumer Protections
 - i. Comparative consumer information
 - ii. Marketing-agents and materials
 - iii. Non-discrimination
 - iv. Continuation of treatment (in the event of insolvency)
 - v. Grievance procedures
 - vi. Advanced directives
 - vii. Financial practices that interfere with quality of care
- c. Reasonable Access
 - i. Assuring access to services for vulnerable populations-ProPAC will complete recommendations within one year, including:
 - (1) Anticipated impact of health reform on access to services for vulnerable populations; and

- (2) Safeguards required to assure continued access to services and reasonable payment for services for vulnerable populations.
 - ii. Anti-redlining rules
 - iii. Provider non-discrimination (e.g., discrimination solely based on the provider's academic degree)
- d. Financial standards (using NAIC model standards)
 - i. Solvency
 - ii. Other financial standards including liquidity, accounting, and reporting
 - iii. Guaranty fund participation

In establishing minimum guidelines, the Secretary (in consultation with the NAIC) will address the issues (and recommend customized guidelines for each) of certification for various models of health plans, taking into consideration:

- a. Multi-state insured plans,
- b. Frontier, rural and inner city considerations (and other start-up issues for small delivery systems in underserved areas), and
- c. Commercial insurance, managed care plans, and delivery-system (provider-based) plans.

6. Consumer Value Program

- a. States shall begin immediately, upon enactment, to establish a consumer value program that results in the distribution of comparative information on health plan offerings and quality outcomes to consumers;
- b. States may designate an independent organization to carry out the consumer value program (giving it deemed status);
- c. The Secretary of HHS will provide to states the minimum guidelines for the consumer value program (see minimum guidelines for comparative consumer information (5.b.i.), including a model "report card" to assure a level of standardization to allow state to state comparisons;
- d. States may exceed the minimum guidelines- federal grants will be available to states for demonstrations experimenting with guidelines beyond the federal minimums;
- e. If the Secretary determines that states have not established a consumer value program within six years, the Secretary may implement such in the state.

7. Pre-emption of State Anti-Managed Care Laws
State anti-managed care laws are preempted, such as:
- a. "Any willing provider" laws;
 - b. Corporate practice of medicine;
 - c. Health benefits mandates;
 - d. Cost-sharing mandates;
 - e. Utilization review mandates; and,
 - f. Involuntary denial of life-saving medical treatment.
8. Administrative Simplification
- a. Secretary of HHS will adopt standards for health data and transactions (from common practices in the private sector). Categories of standards may include:
 - i. Financial, administrative transactions;
 - ii. Enrollment information;
 - iii. Financial and administrative data;
 - iv. Unique identifiers (subject to strict patient confidentiality requirements).
 - b. Use of and access to standard transactions and standard data through the National Health Care Data Network.
 - i. Health plans, providers must keep data available for authorized access and comply with transmission standards set by the Secretary. Clearinghouses may be used to comply.
 - ii. Penalties apply for noncompliance to standards.
 - c. State "Quill Pen" laws are preempted.
 - d. Entities operating in the national health care data network. Secretary develops standards for the Health Care Data Clearinghouses. Private entities may be designated to certify such systems and clearinghouses.
 - e. The Secretary of HHS will set standards for providers and health plans to access information from the network, including standards for privacy. Only minimum data necessary will be disclosed and only when authorized by privacy laws.
 - f. A Health Care Data Advisory Panel will be established to assist the secretary in all standards and processes, including standards for privacy.
 - g. Secretary may authorize grants for demonstration projects.
 - h. Administrative simplification standards and processes will coordinate with the quality and consumer information processes and certification areas.

1. The Medicare/Medicaid data bank (from OBRA93) will be repealed once the administrative simplification system is operational.

9. Authorization of Appropriations

This bill would authorize appropriations for the activities described above.

10. Fraud

- a. The Secretary of HHS and the Attorney General shall jointly establish and coordinate a national health care fraud program to combat fraud and abuse in government and certified health plans.
- b. Monies raised from anti-fraud and abuse penalties, fines, and damages will be dedicated to an account to pay the costs for anti-fraud and abuse efforts.
- c. To give greater guidance to health care providers (so they can comply with fraud and abuse laws), there will be established:
 - i. New safe harbors;
 - ii. Interpretive rulings; and,
 - iii. Special fraud alerts.
- d. The current Medicare and Medicaid penalties for health care fraud and abuse will apply to all health care fraud affecting Federal subsidies or other Federal outlays. These include exclusion from participation in Federal health programs and the imposition of civil money and criminal penalties.
- e. The Secretary will comply with certain requirements to communicate violations anti-fraud and abuse laws.
- f. A new health care fraud statute will be developed modelled after the mail and wire fraud statutes.

B. Building Primary Care Capacity in Underserved Areas

1. Purpose

- a. Safeguards to assist vulnerable populations to access local health services and practitioners;
- b. Funding in certain areas to assist providers and health plans to reconfigure services and establish networks to compete in the changing market;
- c. Funding to increase primary care capacity in underserved areas; and
- d. More flexible Medicare rules for providers in underserved areas.

2. Redefining Underserved Areas in the Changed Market

States to designate frontier, rural and urban areas as underserved taking into account:

- a. Lack of access to health plans; and
- b. Lack of access to quality providers and health care facilities in such areas.

The designations must be approved by the Secretary of HHS. Underserved areas do not need to meet MUA or HPSA definitions. The designation is for no longer than three years. Underserved areas receive priority for special funding included in this section.

3. Network Development Funds

- a. Planning funds
 - i. Medicare and Medicaid waiver demonstrations to form health care networks; and,
 - ii. Grants to private entities and states for use in planning and development of networks of providers and plans.
- b. Technical assistance funds -- to comply with health plan certification guidelines, administrative simplification data and transaction standards, quality assurance activities, consumer information programs, insurance reforms, and other reform requirements; and
- c. Capital (low interest loans) assistance for the reconfiguration of facilities, start-up capital, establishing reserves, and setting up information systems for entities in networks.

4. Increasing the Numbers of Services, Practitioners, and Plans

- a. Loan repayments for primary care practitioners in geographic areas recognized by the Federal Office of Shortage Designation.
- b. Tax incentives:
 - i. A physician who provides primary health services in underserved areas would be eligible for a nonrefundable credit against Federal income taxes of up to 60 months.
 - ii. A physician who provides primary health services in underserved areas would be eligible to take an additional \$10,000 per year as section 179 deduction for health care property placed in service during the tax year.
- c. Increase Federal support for primary and preventive health care services aimed at segments of the population most likely to be uninsured and at high risk:
 - i. Comprehensive Maternal and Child Health coordination aimed at improving health;
 - ii. School-based Health Education -- Increase assistance for pre-school and elementary programs that provide comprehensive health

- education to children; and,
 - iii. Special grants to frontier areas for preventive health services.
 - d. Increase Public Health Act funding for:
 - i. Grants to Community Health Centers, Migrant Health Centers, FQHCs and look-alikes;
 - ii. Increase funding for AHECs through 2000; and
 - iii. Fully fund the National Health Service Corps;
 - e. Funding for telemedicine and related telecommunications technology support for frontier and rural areas; and
 - f. Funding for medical transportation in frontier and rural areas.

5. Payment Flexibility

- a. Extending EACH/RPCH to all states and making technical corrections;
- b. Creating the REACH program;
- c. Extending Medicare Dependent Hospital classification through 1998;
- d. Extend the MAF demonstration to all states; and,
- e. Increase Medicare reimbursement to physician assistants and nurse practitioners in rural and urban areas.

6. Studies, Responsibilities

- a. Propac will make recommendations within six months on the need for any transitional provisions to assure access for vulnerable populations;
- b. The Secretary will study the need for and design of a "supplemental rural benefits package" within six months of enactment; and
- c. An Office of the Assistant Secretary for Rural Health will be established (elevates an existing position) to advise the Secretary on all rural provisions in reform.

7. Anti-Trust Clarifications

- a. Mechanisms for clarification of anti-trust treatment for providers:
 - i. Certificates of Review- providers may apply to the Attorney General for certificates of review to be granted case-by-case.
 - ii. Notification- providers may file a notification of their joint venture activities with the Attorney General. Certain rule of reason analysis and damage rules shall apply in any subsequent suits.
 - iii. Guidelines- the Department of Justice shall issue guidelines clarifying legitimate collaborative activities of health care providers responding to community needs.

- iv. Safe Harbors- The Department of Justice shall develop "safe harbors" in certain health care delivery areas by soliciting input through notice and comment procedures. The safe harbors shall help to reduce both the costs and administrative burdens of antitrust regulation reviews. Certain rules of enforcement and defense shall apply for organizations and ventures falling within the safe harbors. Certain areas must have safe harbor clarifications by the Justice Dept.

C. Health Professionals

1. Education

a. Oversight:

i. Establish Independent, Advisory Commission on Workforce --

- (1) Federal oversight will be limited to an independent, non-governmental advisory council to the Congress, modeled on PROPAC and PPRC. COGME will be discontinued, with its funds used to partially finance the new Commission.
- (2) The composition of the board will include experts in medical education, teaching hospitals, health plans, and other relevant parties.
- (3) Sets in law the role of the Commission and a timetable for reports on specific questions of workforce policy and payment, including but not limited to:
 - (a) Profile the composition of the physician and non-physician workforce and address how the composition (numbers and mix) fits market needs;
 - (b) Amounts and process for funding;
 - (c) Future payment policy for Medicare for graduate medical education;
 - (d) Incentives for primary care and underserved areas;
 - (e) Foreign medical graduates' policy;
 - (f) Future direction and coordination of grants, demonstrations, and other funding affecting the workforce.

b. Increasing Primary Care Practitioners and Ambulatory Training.

- i. Consortia demonstrations to increase primary care. The Secretary will conduct 10 Medicare

- demonstrations for the purposes of increasing the numbers of primary care practitioners trained (graduate education). The demonstrations may be multi-state. All Medicare DME funds historically used in the geographic area may be distributed to consortia. Criteria for consortia will be established by the Secretary. Additional incentives dollars may be paid to consortia from any savings from IME reductions.
- ii. Non-hospital-owned ambulatory sites will be eligible to receive DME payments.
 - c. Biomedical and Behavioral Research. A voluntary check-off on individual income tax returns will be established to contribute dollars to a national research fund.

2. Malpractice

- a. Cap on Non-Economic Damages at \$250,000, with entity established to study a schedule of caps for congressional consideration.
- b. Several Liability for non-economic and punitive damages.
- c. Periodic Payments for damages of over \$100,000, with judge given discretion to waive in interests of justice.
- d. Collateral Source Rule - collateral sources are deducted from award to plaintiff.
- e. Limits on Attorney Fees - Limited to 33 1/3% percent of the first \$150,000 and 25% of amount over \$150,000, after taxes.
- f. Statute of Limitations - two years from date of discovery and no later than 5 years after occurrence. Claim may be initiated for minors under age six if two years from date of discovery and no later than six years after occurrence or before minor turns 11, whichever is later.
- g. Clear and Convincing Standard for first seen obstetric cases.
- h. Punitive Damages Reform. Includes Clear and Convincing Standard of proof; elements of proof; pleading and process requirements; cap on punitive damages (lesser of 2x compensatory damages or \$500,000); dedication of 50% of award to health care quality assurance program.
- i. Right of Subrogation or Automatic Subrogation under Collateral Source Rule.
- j. Prohibition on Vicarious Liability.
- k. All provisions cover all defendants in any Health Care Liability Action.
- l. Consumer Protections - Require Risk Management by health care professionals, providers and insurers;

permits licensure boards to enter agreements with professional societies to license and review health care professionals; liability protection for state licensure boards.

D. Long-Term Care

1. Tax clarification

- a. All long-term care services are treated as medical expenses under the tax law, meaning that --
 - i. Long-term care expenses and insurance premiums above 7.5% of AGI would be deductible from income; and,
 - ii. Payments under long-term care insurance policies would not be taxable when received.
- b. Insurance companies can deduct their reserves set aside to pay benefits under long-term care insurance policies.
- c. Permit long-term care riders on life insurance policies and treat like long-term care, not like life insurance.
- d. Do not permit tax-free exchange of life insurance contract to long-term care.
- e. Exclude certain accelerated death benefits from taxable income.

2. Minimum Standards for Long-Term Care Insurance

In order to receive favorable tax treatment, long-term care insurance policies would have to meet certain consumer protection standards. These standards include provisions based on the NAIC Model Act and Regulation (as of January, 1993) and supported by the insurance industry.

3. A nonrefundable tax credit of up to 50 percent of an employed individual's personal assistance expenses of up to \$15,000 per year will be provided.
4. Modifications to Medicaid long-term care (see below).
5. Acute/LTC integration demonstration project.

III. IMPROVED FEDERAL HEALTH PROGRAMS

A. Medicaid

1. Acute Care

- a. Beginning 1/1/00, all AFDC and non-cash Medicaid recipients will be integrated into the low-income subsidy program. These individuals will no longer

- be entitled to acute care benefits under Medicaid, but would receive private health insurance through the low-income subsidy program. Supplemental benefits will be provided under a capped entitlement to the states. Nothing in this section should be construed as affecting an individual's eligibility for long-term care services under Medicaid.
- b. Individuals eligible for AFDC and non-cash Medicaid recipients whose income exceeds the income thresholds of the low-income subsidy program would be grandfathered, i.e., deemed to have income below 100% percent of the Federal poverty level, and therefore eligible for a full premium subsidy.
 - c. Like all other individuals eligible for the low-income subsidy program, AFDC and non-cash Medicaid recipients would receive premium subsidies, up to a maximum amount, for the purchase of a certified health plan covering the FedMed benefit package.
 - d. Medicaid acute care (non-long-term care) services not covered by the FedMed benefit package would be provided as supplemental benefits under a capped entitlement program to the states, based on historical Medicaid spending for these services, plus a growth factor.
 - i. States could provide these supplemental benefits to any individual qualifying for the low-income subsidy program.
 - ii. States may give priority for the supplemental benefits to children, pregnant women, and individuals in medically underserved areas.
 - iii. At the end of each Federal fiscal year, states may apply for any Federal funds for supplemental benefits not allocated to other states.
 - e. SSI and SSI-related (e.g., state SSP) recipients would generally remain eligible for services under the traditional Medicaid program. However, states would be given additional flexibility to enroll SSI and SSI-related recipients in Medicaid managed care programs, or in certified health plans covering the FedMed benefit package at a negotiated premium rate. The number of individuals electing to enroll in a certified health plan will be limited to 15% of the eligible SSI and SSI-related Medicaid population in the state in each of the first 3 years (beginning 1/1/97), increasing by 10 percentage points (e.g., 25, 35, 45, etc.) in each year thereafter.

- f. State maintenance of effort.
- i. States will make "maintenance of effort" (MOE) payments to the Federal government in an amount equal to each state's spending on acute care services covered by the FedMed benefit package for AFDC and non-cash recipients under Medicaid in the year prior to integration.
 - ii. Each state's MOE payment will be increased annually from the previous year by the weighted average increase in the maximum premium subsidy amounts in the state under the low-income subsidy program, plus the change in the state's population.
 - iii. Federal spending for the supplemental benefits will be based on Federal spending for AFDC and non-cash recipients for non-long-term care, non-FedMed-related Medicaid acute care services in the year prior to which the state's AFDC and non-cash recipients become eligible for the low-income subsidy program. Federal expenditures will increase annually from the previous year by the weighted average increase in the maximum subsidy amounts in the state under the low-income subsidy program, plus the change in population.
 - iv. At least 3 months prior to the date AFDC and non-cash recipients are integrated into the low-income subsidy program, the state must have an integration plan approved by the Secretary of HHS. The final plan will specify the state's MOE obligation.
- g. Transition.
- i. The bill establishes a Medicaid risk contract program which would allow states (at their option) to enter into risk contracts with organizations that meet Federal standards for access, enrollment, and quality assurance.
 - ii. Upon enactment, states would be permitted to:
 - (1) Enroll any groups of Medicaid recipients in Medicaid risk contract programs or private health plans (states would be required to offer recipients a choice of at least 2 plans); or,
 - (2) Apply for 1115 demonstration waivers.
 - iii. States with existing 1115 demonstration waivers would be allowed to continue until the state or the Secretary terminates the waiver, or until 1/1/00, whichever is earlier.

- iv. At any point after enactment, states may apply for a waiver from the Secretary of HHS to integrate its AFDC and non-cash recipients into the low-income subsidy program when the low-income subsidy program begins (1/1/97). All states must integrate their AFDC and non-cash recipients into the low-income subsidy program by 1/1/00.
- v. Beginning 1/1/97, Federal and state expenditures for FedMed-related acute care services would be capped on a per capita basis at the Federal and state matching rates multiplied by the weighted average maximum premium subsidy amount in the state. Federal expenditures for non-long-term care, non-FedMed-related acute care services would become a capped entitlement to states, based on Federal expenditures for such services in the state in the base year, increased annually by the increase in the weighted average maximum premium subsidy amount in the state.
- vi. For states that integrate AFDC and non-cash recipients into the low-income subsidy program before 1/1/00, states will make "maintenance of effort" (MOE) payments to the Federal government in an amount based on each state's spending for acute services covered under the FedMed benefit package for AFDC and non-cash recipients in the year prior to which the state's AFDC and non-cash recipients become eligible for the low-income subsidy program.
- vii. Each state's MOE payment for the FedMed-related services will be increased annually from the previous year by the weighted average increase in the maximum premium subsidy amounts in the state under the low-income subsidy program, plus the change in the state's population.
- h. Federal Medicaid DSH expenditures will be reduced by 25 percent. The Secretary shall make recommendations regarding phasing out the DSH program or integrating the DSH expenditures into the per-capita amount as coverage increases.
- i. Federal match rates would not be changed except to fix inequities for Alaska.

2. Long-Term Care

- a. Eliminates the need for waivers to provide home- and community-based long-term care services under Medicaid (i.e., make them a state plan option).

- b. Codifies that the "cold bed rule" does not apply (i.e., states can provide services to more individuals than there are nursing home beds in the state).
- c. Allows On-Lok/PACE to expand sites and to be afforded provider status under Medicare/Medicaid.
- d. Allows states to pursue public-private partnership programs that link Medicaid eligibility to the purchase of a qualified private long-term care insurance policy. Policies would have to meet Federal standards described in the tax code (see also "Long-Term Care").

B. Medicare

- 1. Medicare remains a separate program.
- 2. The Secretary of Health and Human Services will make recommendations to Congress, within one year of enactment, on the following:
 - a. Allowing Medicare beneficiaries the option of:
 - i. Enrolling in private health plans; and,
 - ii. Establishing Medical Savings Accounts.
 - b. Allowing Medicare-eligible military retirees to enroll in health plans sponsored by the Department of Defense or other appropriate federal health programs.
- 3. Improve risk contracts
 - a. The Secretary shall provide Medicare beneficiaries information on Medicare options available in a beneficiary's area.
 - b. Improvements in Medicare risk contract payment methodology:
 - i. The Secretary shall establish Medicare rating areas to replace the current county based system. Metropolitan Statistical Areas may not be divided into different rating areas.
 - ii. In determining the amount of payment for Medicare risk contracts, the Secretary shall use a direct calculation methodology applied to each rating area, adjusted to reflect the use of military, veterans, and other federal health program services.
 - c. HMOs will have the option of requiring Medicare beneficiaries that enroll in risk contract plans to disenroll only during an annual enrollment period. HMOs choosing this option must inform Medicare beneficiaries of the disenrollment limitation prior to enrollment.

- d. The Secretary of HHS may waive 50/50 rule (at least 50 percent of enrollment be non-Medicare) for Medicare risk contractors that meet certain quality standards.
4. Medicare Select will be a permanent Medigap option in all states.
5. The Social Health Maintenance Organization demonstration project is extended for two years.

C. Veterans Affairs

1. Grants VA sufficient flexibility to enable the VA to respond rapidly and effectively to Federal and state market reforms.
2. Grants the Department of Veterans Affairs the necessary legal authority and resources to respond effectively.

IV. FINANCING

A. Spending Savings

1. Medicare Savings
 - a. **Reduce Hospital Market basket Index Update.** This proposal reduces the Hospital Market Basket Index Update by 1%. Currently Medicare changes the inpatient per-discharge standardized amount by a certain amount every year to reflect input costs changes in Congressional direction. OBRA 1993 reduced the Index in Fiscal Years 1994 through 1997. This proposal would reduce the updates by 1% for Fiscal Years 1997 through 2000.
 - b. **Adjust Inpatient Capital Payments.** This proposal combines three inpatient payment adjustments to reflect more accurate base year data and cost projections. The first would reduce inpatient capital payments to hospitals excluded from Medicare's prospective payment system by 15%. The second would reduce PPS Federal capital payments by 7.31% and hospital-specific amount by 10.41% to reflect new data on the FY 89 capital cost per discharge and the increase in Medicare inpatient capital with a 22.1% reduction to the updates of the capital rates.
 - c. **Revise Disproportionate Share Hospital Adjustment.** This proposal phases down, but does not eliminate, the current disproportionate share hospital adjustment over five years.

- d. **Indirect Medical Education (IME).** This proposal lowers the IME adjustment for teaching hospitals from 7.7 percent to 6.7 percent. (The IME adjustment recognizes teaching hospitals' higher costs for offering a wider range of services and technologies, caring for more severely ill patients, and providing more diagnostic and therapeutic services to certain types of patients than other hospitals.)
- e. **Partially Extend OBRA 93 Provision to Catch-up after the SNF Freeze Expires Included in OBRA 93.** Sets SNF cost limits at 106% of the mean. OBRA 93 established a two-year freeze on update to the cost limits for skilled nursing facilities. A catch-up is allowed after the freeze expires on October 1, 1995. This bill allows a partial catch up for nursing homes while still realizing savings.
- f. **Partially Extend OBRA 93 Provision to Catch-up After the Home Health Freeze Expires.** Sets cost limits for home health at 106% of the mean. OBRA 93 eliminated the inflation adjustment to the home health limits for two years. This bill allows a partial catch-up for home health after the freeze expires on July 1, 1996.
- g. **Moratorium on New Long-term Care Hospitals.** This proposal eliminates new designations of PPS-exempt long-term care hospitals.
- h. **Change the Medicare Volume Performance Standard to Real Growth GDP.** This changes the formula that is used to calculate the target rate of growth for Medicare physician services. This change directly connects the growth in physician services to the growth of the nation's economy.
- i. **Establish Cumulative Growth Targets for Physician Services.** This changes the formula used to calculate the target rate of growth for Medicare physician services. Under this provision, the Medical Volume Performance Standard for each category of physician services would be built on a designated base-year and updated annually for changes in beneficiary enrollment and inflation, but not for actual outlay growth above and below the target.
- j. **Reduce the update in the Medicare Fee Schedule Conversion Factor by 3% in 1995, except Primary Care Services.** The conversion factor is a dollar amount that converts the physician fee schedule's relative value units into a payment amount for each physician service. This provision reduces the 1995 annual update by 3%.

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To: Tennesseans Following Health Care Reform

From: Congressman Jim Cooper

Date: Friday, August 13, 1993

WASHINGTON TURNS TO HEALTH CARE REFORM

Now that his budget plan has been enacted, the President and Congress will turn their attention to health care reform. September 21 is the current target date for release of the Administration's plan -- probably before a joint session of Congress -- but the general framework may be laid out as early as next Monday in President Clinton's address to the National Governors' Association.

Conservative and moderate Democrats continue to have grave reservations about what we have heard of the proposal. I have been leading meetings of like-minded Members of Congress with representatives of the White House to communicate these concerns. As many of you know, until now I have withheld reintroducing my managed competition bill, preferring to work with the White House to develop a plan which could receive bipartisan support.

SINGLE-PAYOR ADVOCATES GAIN STEAM

However, Congressional advocates of a Canadian-style, government-run system have not been so cooperative. They have attacked the Administration's plan at every opportunity, introduced their own bill and garnered 86 cosponsors, despite the Congressional Budget Office's estimate that their proposal would require raising about \$600 billion a year in new taxes.

As a result, the White House now appears to be more worried about losing the support of the single-payor advocates than they are about losing moderate Democrats. This is short-sighted. One thing that the battle over the deficit-reduction plan taught us is that health care reform must be bipartisan in order to pass. Pure, market-based managed competition, as I have proposed, is the only plan with true bipartisan support in Congress.

EMPLOYER MANDATE RECEIVES MORE SCRUTINY

In another important signal, last week forty-one Republican senators sent a letter to the President opposing a mandate on employers to purchase health coverage for their employees. This means that even without any Democrats (of which there are many who would agree), Republicans could sustain a filibuster in the Senate over any bill containing such a provision.

The Healthcare Leadership Council recently commissioned the respected consulting firm Lewin-VHI to study the impacts of an employer mandate under the best available version of the Clinton plan. Their state-by-state analysis concludes that the Clinton mandate would increase aggregate health care costs for Tennessee employers by 88%. Employers nationwide would pay on average 53% more.

WHITE HOUSE PLAN LIKELY TO ALIENATE MODERATES

Unfortunately, it now seems virtually certain that the President's plan will include not only an employer mandate, but also a global budget on private sector health care spending enforced by price controls on health plans. In addition, the White House Task Force has transformed managed competition's purchasing cooperatives into government Health Alliances with the power to regulate and exclude health plans. The proposal is also likely to lack key elements of managed competition, such as an effective limit on tax deductibility to encourage cost containment.

In order for moderates to show the breadth of support for real, market-based reform in Congress, we need to have a rallying point. Therefore, I will have my bill ready to reintroduce when Congress returns to Washington next month. My colleagues and I in the Conservative Democratic Forum have been working closely with the Congressional Mainstream Forum and the Democratic Leadership Council to build support for this approach.

I was recently asked by the Congressional newspaper Roll Call to describe the important ways in which the original managed competition differs from the hybrids. I have no pride of authorship in my proposal; it's not perfect. But I do feel that in order for health care reform to work, it must be internally consistent. Unfortunately, many of the adaptations of managed competition, in my view, make it unworkable. I have attached the article for your information.

P.S. For those of you who have been forwarding these letters to the White House, you no longer need to waste your stamp. The White House is now on the mailing list.

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**Congress of the United States
Washington, DC 20515**

August 4, 1993

Dear Colleagues,

Before leaving town for the August work period, we want to bring you up to date on the CDF's market-based health care reform initiative.

As you know, we made history last year by introducing the "Managed Competition Act", H.R. 9936. Prior to the CDF Health Care Reform Task Force's involvement in the debate, managed competition was virtually unknown in Washington. Now it forms the basis of the Administration's upcoming health care proposal.

Many of you have asked us when the bill will be reintroduced. Until now, we have held off on reintroduction with the hope that we could work with the Administration to develop a managed competition plan which we could support. We have been meeting regularly with the First Lady and her senior health care advisor Ira Magaziner urging them to stick with pure managed competition and reject the heavy-handed government regulation that is being pushed by those who favor a Canadian-style health care system.

While the President has yet to make some final decisions, it seems virtually certain that his proposal will include a mandate on employers to purchase health coverage for their employees and a "global" limit on private sector health care spending enforced by price controls on health plans. His plan is also likely to lack key elements of managed competition, such as an effective limit on employer tax deductibility to encourage cost containment.

The advocates of a Canadian single-payer approach already have 85 cosponsors in the House and appear to have momentum on their side. Despite their highly-public break with the President, they are being catered to by the White House. We need to make a stronger statement about the support among Democrats for market-based reform. And we need to do that so it is clear we are trying to help the President develop a plan that actually has support enough to pass.

We are interested in hearing your thoughts about the best way to proceed. We still hold out hope that we can support the President's plan, but we are redrafting the bill for reintroduction after the August break. Our intention is to send you a draft of the new bill the week of August 23rd and to seek your input on the following week when we will be back in Washington.

Sincerely,

Jim Cooper *Michael A. Andrews* *Charlie Stanholm*
Jim Cooper Michael A. Andrews Charlie Stanholm

Press Conference Statement
by
Rep. Jim Cooper (D-TN)
October 6, 1993

[Before beginning, I would like to thank the extraordinarily talented staff for their able assistance, particularly Anand Raman, Atul Gawande, Caroline Chambers, Dave Kendall, and Colleen Kepner. None of us would be here without their remarkable work.]

My name is Jim Cooper. I am a Democratic congressman from Tennessee. Today we formally introduce the Managed Competition Act of 1993. It is the only comprehensive, bipartisan health reform plan in the 103rd Congress.

Standing with me are some of the 46 original cosponsors of the bill, 27 Democrats and 19 Republicans. A companion bill is expected to be introduced in the Senate in the next few days under the sponsorship of Senators Breaux and Durenberger.

All of us want health care reform to pass in this Congress and to be signed into law by the President. We applaud President and Mrs. Clinton's leadership in this vital domestic policy issue. We particularly applaud the First Lady's courage, vision, and outreach. No one could have worked harder, more compassionately, or more intelligently than she has to try to solve our health care problems. As the former Surgeon General, Dr. C. Everett Koop, has said, the Clintons have already shown more leadership in health care than all of their living predecessors combined.

These are tough issues; that's why most Presidents avoid them. But we share the White House's view, and the American people's view, that much of our health care system is broken and must be fixed... now.

When the President addressed the Joint Session of Congress two weeks ago, he said that there was room for honest disagreement on the best way to reform our health care system. While we support a great deal of what we know of the Administration's plan, we do have some serious concerns that must be addressed.

Areas of Agreement

We agree with the Administration that all Americans should be able to get health insurance and keep it no matter how sick they have been, where they work, or if they switch jobs. No American

will live in fear of a pre-existing condition or bad experience rating again. The price of coverage must also be affordable. We should help all of the poor and near-poor buy coverage, and enable everyone to obtain it at the lowest possible group rates, as if they worked for a Fortune 500 company. We also think the self-employed should be able to deduct 100% of the cost of health coverage.

We agree with the Administration that more Americans should be able to choose their favorite doctor instead of having to put up with their boss' choice. Nine million federal employees have expanded their choices and held down costs for thirty years using an annual menu shopping system that even the Heritage Foundation says is one of the best government programs in history. It's high time we shared that with all Americans, simplifying the menu by adding a standard benefits package. The price and quality of health care should be disclosed in advance so that all Americans can finally shop for health care the way they shop for everything else.

We agree with the Administration that preventive care, primary care, rural and inner-city care must be emphasized. Outcomes reporting, practice guidelines, gatekeepers and case managers should be utilized to help us get more value for our health care dollars. Like the Administration, we want the people to choose their favorite delivery system for health care, whether it is an HMO, PPO, IPA, POS, or regular fee-for-service medicine. Uniform claims forms and electronic processing will help us cut through the health care red tape. Malpractice reform is also necessary to help reduce the cost of defensive medicine.

We agree with the Administration that today's health care system has one of the worst incentive structures possible. It makes more money off of us the sicker we are and the more tests that are run. The system should have an incentive to keep us healthy and to do the right number of tests.

Not Managed Competition

Despite all of this bipartisan support for so much of the President's plan, we still think it falls short of real managed competition. Likewise, the various Republican plans fall short. Why does this matter? Because we feel that managed competition will work better back home and may be the only way to break the partisan gridlock in Washington.

We think that fledgling versions of managed competition are already working in California, Minnesota, Florida, and Washington State. One hundred fifty American cities already have employer purchasing coalitions. The Federal Employee Health Benefits System is a nationwide managed competition model.

The Administration started with managed competition and went to the left. The Republicans took managed competition and went to the right. Our bill is squarely in the middle, and is the only one with significant bipartisan support. It is the first health reform approach since Harry Truman to get major Democratic and Republican support. The New York Times, Fortune, and U.S. News & World Report have already predicted that the final legislative compromise will be very close to our bill.

We have no pride of authorship. Although several of us had introduced the first managed competition bill in history, H.R. 5936, in the last Congress, and although both President Bush and then-Governor Clinton endorsed managed competition in the last election, we chose not to introduce our bill in this Congress. Others introduced their health reform bills, but we did not. We hoped that the Administration would adopt enough of our ideas so that we would not have to introduce.

The father of managed competition, the Jackson Hole Group, and the leading exponents of it, the Conservative Democratic Forum (CDF) and the Democratic Leadership Council (DLC), have all concluded that the public should be able to see a real managed competition bill so that they can decide which plan is the best medicine. This issue will be, and should be, decided around the kitchen tables of America.

As my colleague Fred Grandy will mention, we object to employer mandates, global budgets, price controls, restrictive/regulatory purchasing cooperatives, excessive state flexibility and the continuation of unlimited corporate tax deductibility for health benefits. We want to hold down health care costs and to expand access using market forces, not big government.

We have grave concerns about a plan that allows any state to adopt a single-payer health system, but allows no state the chance to have real managed competition reform.

Continue the Dialogue

Our reluctant introduction of this bill is not an end to our dialogue with the White House and others on health reform. We fully realize our bill is not perfect, and are anxious to improve it. There are already parts of it that I and others would like to change. But it is a true bipartisan plan, and that is the best way to begin a debate on reshaping one-seventh of the U.S. economy. We need the collective wisdom of both political parties to help us find the right solutions.

Our purpose is entirely constructive. We emphasize what we are for. We have a bill that people can see and criticize before President Clinton or Senator Chafee have even introduced theirs.

As the former Speaker of the House, Sam Rayburn, once said, "Any mule, or elephant for that matter, can kick a barn down. It takes a carpenter to build one." I can guarantee you that every one of our original cosponsors is in the carpentry business.

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THERE ARE SEVERAL SUBSTANTIVE AND POLITICAL PROBLEMS WITH THE COOPER/BREAUX 91% APPROACH:

- **LEAVES MILLIONS OF AMERICANS UNINSURED** 25 MILLION AMERICANS WOULD BE UNINSURED. AS MANY AS 40 MILLION AMERICANS WOULD BE WITHOUT HEALTH INSURANCE FOR SOME PERIOD OF TIME EACH YEAR. ALMOST ALL OF THE NEWLY INSURED WOULD BE UNDER THE POVERTY LEVEL. BECAUSE THE SUBSIDIES BECOME LESS GENEROUS THE MORE AN INDIVIDUAL EARNS, VERY FEW MIDDLE-INCOME AMERICAN FAMILIES BECOME NEWLY INSURED UNDER THIS PROPOSAL. IN FACT, 8 MILLION PEOPLE, PRIMARILY MIDDLE-INCOME AMERICANS, WHO NOW HAVE INSURANCE WOULD BE DROPPED.
- **INCREASES THE DEFICIT** FROM 1996-2004, THE FEDERAL DEFICIT INCREASES BY OVER \$300 BILLION TO FUND SUBSIDIES AND TAX INCENTIVES TO MAKE PURCHASING INSURANCE MORE AFFORDABLE. THE DEFICIT INCREASES DESPITE TAXING EMPLOYER BENEFITS ABOVE THE LOW-COST PLAN IN AN AREA.
- **PLACES HEAVY BURDEN ON INDIVIDUALS** MANY PEOPLE, EVEN WITH SUBSIDIES, WILL PAY OVER 10% OF THEIR GROSS INCOME FOR HEALTH INSURANCE. A WORKER EARNING \$30,400 COULD HAVE TO SPEND OVER \$6000 TO BUY A FAMILY POLICY AND WOULD NOT BE ELIGIBLE FOR GOVERNMENT SUBSIDIES.
- **MAY ENCOURAGE EMPLOYERS TO DROP COVERAGE** THE EXISTENCE OF LOW-INCOME SUBSIDIES MAY ENCOURAGE FIRMS THAT CURRENTLY PROVIDE HEALTH INSURANCE TO DROP COVERAGE FOR LOW-WAGE WORKERS. THE LEWIN ANALYSIS ASSUMES THAT FIRMS CURRENTLY PROVIDING HEALTH INSURANCE WILL CONTINUE TO DO SO, EVEN THOUGH FIRMS

HAVE BEEN DROPPING HEALTH CARE COVERAGE IN TODAY'S
SYSTEM. FROM 1989 TO 1992, THE NUMBER OF AMERICANS WITH
EMPLOYER COVERAGE DROPPED BY 3 MILLION.

THIS IS NOT UNIVERSAL COVERAGE.

IF A COMPROMISE REQUIRES A TRANSITION TO UNIVERSAL COVERAGE, HOW DO WE DESIGN A PROGRAM TO:

- ENHANCE PROTECTION AND MINIMIZE DISRUPTION DURING TRANSITION
- MAKE PROGRESS TOWARD UNIVERSAL COVERAGE AT AFFORDABLE COST
- ALLOW AFFORDABLE UNIVERSAL COVERAGE AT THE TRANSITION'S END

ENHANCING PROTECTION AND MINIMIZING DISRUPTION

GAINS IN TRANSITION:

- **ENDS INSURANCE DISCRIMINATION BASED ON HEALTH STATUS, THEREBY ENHANCING PORTABILITY OF COVERAGE**
- **SUBSIDIES TO FAMILIES AND EMPLOYERS MAKE INSURANCE MORE AFFORDABLE**
- **PUTS IN PLACE THE BEGINNING OF A FRAMEWORK TO ACHIEVE UNIVERSAL COVERAGE**

RISKS OF DISRUPTION IN TRANSITION:

- **IN A VOLUNTARY MARKET WITH FULL COMMUNITY RATING, INSURANCE PREMIUMS WILL RISE FOR THE YOUNG AND HEALTHY, LEADING EMPLOYERS TO DROP COVERAGE**
- **IN A VOLUNTARY MARKET, REQUIREMENT OF A SINGLE BENEFIT PACKAGE MAY LEAD EMPLOYERS WITH LESS COMPREHENSIVE PACKAGES TO DROP COVERAGE**

STRATEGIES TO MINIMIZING DISRUPTION:

- **DESIGN TRANSITIONAL INSURANCE REFORMS TO RETAIN AGE RATING AND WAITING PERIOD FOR COVERAGE OF PREEXISTING CONDITIONS AMONG THE NEWLY INSURED**
- **ALLOW THE OFFERING OF A BENEFITS PACKAGE THAT IS LESS GENEROUS THAN THE STANDARD PACKAGE**

MAKING PROGRESS TOWARD UNIVERSAL COVERAGE

PROBLEMS WITH PHASING IN UNIVERSAL COVERAGE:

- INITIAL SUBSIDIES GO OVERWHELMINGLY TO THE ALREADY INSURED, RAISING QUESTIONS ABOUT THE EFFICIENT USE OF GOVERNMENT FUNDS.
- WITHOUT COST CONTAINMENT, SUBSIDY AND PREMIUM COSTS BECOME UNAFFORDABLE, BOTH DURING AND AFTER TRANSITION. IF THIS OCCURS, "TRIGGERS" WILL NEVER BE PULLED.
- POLITICAL PRESSURE IN OPPOSITION TO PULLING THE TRIGGER WILL PERSIST

STRATEGIES TO MINIMIZE PROBLEMS:

- LIMIT OR TARGET SUBSIDIES DURING TRANSITION
- PHASE IN BENEFITS AS COVERAGE PHASES IN
- ACCOMPLISH PARTIAL COST CONTAINMENT, AT LEAST BY LIMITING FEDERAL GOVERNMENT'S EXPOSURE
- ASSURE AVAILABILITY OF AFFORDABLE COVERAGE DURING TRANSITION, PERHAPS THROUGH FEHBP-LIKE MECHANISM
- GIVE CLEAR INDICATIONS OF COMMITMENT TO UNIVERSAL COVERAGE, FOR EXAMPLE, THROUGH EARLY MANDATES FOR VERY LARGE FIRMS OR FOR KIDS

EACH OF THESE STRATEGIES REQUIRES FURTHER ANALYSIS TO DETERMINE THEIR VIABILITY.

**ACHIEVING AFFORDABLE UNIVERSAL COVERAGE
AT TRANSITION'S END**

WITHOUT FULL COST CONTAINMENT, PUBLIC AND PRIVATE, COSTS OF UNIVERSAL COVERAGE WILL RISE OVER TIME, THREATENING FISCAL CAPACITY TO PULL THE TRIGGER.

TO ASSURE AFFORDABILITY ONCE TRIGGER IS PULLED, CONSIDER:

- REDUCED BENEFIT PACKAGE WHEN TRIGGER IS PULLED
- REDUCED SUBSIDIES WHEN TRIGGER IS PULLED
- GUARANTEED AVAILABILITY OF COST CONSTRAINED COVERAGE THROUGHOUT TRANSITION

THE NEW REPUBLIC

FEBRUARY 7, 1994

Why the Cooper plan won't wash.

COOPER POOPER

By Harris Wofford

After a season of new health care proposals, political posturing and broad-brush propaganda by private interest groups, Congress is about to get down to work on crafting a comprehensive health care plan. The final result should be a private-sector system that has lower inflation than our present one, has less bureaucracy and offers greater individual choice among doctors and health plans.

That happy prediction is based on something like Winston Churchill's wartime faith in the American people. In 1941, when Britain's survival hung by a thin transatlantic lifeline, Churchill said he was confident that the Americans "in the end will do the right thing ... after they have tried every other alternative."

Doing the right thing in health care means achieving two basic goals: guaranteeing coverage for every American and checking the escalation of costs. The challenge is for members of Congress to reach across ideological lines and work with the president to overcome the resistance to reform that thwarted Harry Truman and Richard Nixon alike. Political fantasy? No. Pennsylvania's 1991 special election showed that health care is too important to ignore. It's a problem not only of the poor and uninsured, but of the middle class, which is

concerned about the cost and security of its coverage.

So now there are plenty of "reform" plans on the table, most importantly the president's Health Security Act, of which I am a co-sponsor. THE NEW REPUBLIC, in a recent editorial ("For the Cooper Plan," December 6, 1993) is right that no measure will pass without the support of proponents of Representative Jim Cooper's plan (and backers of Senator John Chafee's Republican proposal and Representative Jim McDermott's "single-payer" plan). And it's right to discard proposals like Senator Phil Gramm's as "hardly worth taking seriously" because they do so little to achieve universal coverage or limit rising costs. But to ask Congress to accept only the half-steps proposed by Jim Cooper is to risk losing a historic opportunity.

As thoughtful as he is, Cooper's bill does not do what needs to be done. He promises "universal access," but that's not saying much. As my colleague Tom Daschle puts it, we all have "universal access" to Rolls Royce dealerships. That doesn't put us behind the wheel. In fact, according to the Congressional Budget Office, Cooper's plan would leave 22 million people without coverage. Yet a recent *NBC/Wall Street Journal* poll shows that 78 percent of Americans see guaranteed coverage as the sine qua non of health reform.

Changing certain insurance industry practices will improve the availability of coverage: portability of coverage from job to job, a prohibition against denying coverage on the basis of pre-existing conditions. These are part of the Cooper plan—and the president's—but they don't guarantee universal coverage. Health plans must also be required to "community-rate." That is, they must charge all enrollees in a certain area the same amount. Without this step, they will still discriminate against people: not by excluding them but by charging them exorbitant premiums.

While Cooper's plan reflects a healthy skepticism about government's ability to solve every problem, it shows how a little reform can be a dangerous thing. He calls his plan "Clinton-lite." It has the distinction of being both less filling and more expensive. For the Cooper plan is "lite" on reaching comprehensive coverage, but it's heavy on family pocketbooks—as well as the national budget. Unlike the president's plan, the Cooper bill would increase the deficit by some \$70 billion over five years, according to CBO/Joint Tax Committee estimates. That doesn't sound very "New Democrat" to me. Nor does the plan's reliance on the IRS: it would create a new layer of government paperwork for every employer by having the agency enforce the cap on tax deductibility.

The Cooper plan would do nothing to reverse the present trend toward limiting people's choice of their own doctors and pressing them into low-cost HMOs. Indeed, by making employers pay taxes on any health premiums higher than those of the lowest-cost plans, it would speed up the process of restricting choice.

Like the president, Cooper proposes reducing the rate of growth in Medicare and Medicaid. But he does so without controlling spending on the private sector

side. As a result health care providers will shift costs, as they do today, by charging their privately insured patients more. Unlike the Health Security Act, the Cooper bill includes no protection for early retirees, who are increasingly seeing their coverage cut off by former employers. It doesn't begin to face the challenge of long-term care. And it doesn't cover prescription drugs for the elderly.

Crafting health care reform isn't a multiple-choice question with one right answer; it's an essay in which many primary sources contribute to the final product. Cooper himself lists fifteen similarities between his proposal and the president's, as well as eight key differences. He calls the plans "first cousins" and suggests a "family reunion" in any final legislation.

The most fundamental agreement is that competition should be promoted by regional purchasing groups through which individuals and businesses would buy coverage. Cooper calls them "Health Plan Purchasing Cooperatives"; the president calls them "Health Alliances." But this rose by either name is the agency for the "managed competition" Cooper has championed. Cooper should declare victory (and Congress should adopt many of his provisions to assure that the groups are consumer-run cooperatives, not new government agencies). The common ground also includes a standard claims form, electronic billing and consumer "Report Cards" on the competing plans. And there is agreement that Medicaid should be replaced, so the poor can have the same choices as everyone else.

So what is holding us back? Rhetoric aside, the fight is over this: Should employers continue to pay health care premiums and should the present employer-employee contribution system be extended to all employers and their workers who are uninsured? Or should the only "mandate" be put on individuals and families, with the help of some new government subsidies?

Supporters of the Cooper and Chafee plans aren't willing to insist that all employers contribute. That may appear like political practicality. But it runs into a harsh reality: any plan that does not provide for a shared employer-employee responsibility would put great financial pressure on companies to dump coverage and shift billions in cost onto working families. The fact is most insured Americans now receive coverage through employers. The Cooper plan could mean that a family earning \$30,000 per year would have to spend what *The New York Times* labeled a "merciless" \$5,000 per year for basic coverage.

Restraint may be a virtue. Far more virtuous, however, would be to fulfill Truman's promise of universal, private health insurance. Jim Cooper's proposal fails that test. So having considered the alternatives, we should in the end, as Churchill suggested, "do the right thing."

HARRIS WOFFORD is a Democratic senator from Pennsylvania.



GEORGETOWN UNIVERSITY MEDICAL CENTER

Institute for Health Care Research and Policy

FACSIMILE COVER SHEET

TO: CHRIS

FAX Number:

FROM: Jeanne

Pages:

- Comments:
- (1) COMPLETE DOLE MEMO. I ALSO FOUND A 27 page version. Do you WANT IT? Yes
 - (2) First Page of a CBO memo - we should start de-emphasizing private growth rate of 7%, because it is likely to change
 - (3) THE DEFICIT reduction book from CBO is out today. You PROBABLY ALREADY ARE ON TOP OF IT, BUT OMB SHOULD BE COMMENTING / CRITICIZING.
 - (4) I NEED TO TALK TO YOU ABOUT THE ICIDS + THE TO ESTIMATES.

DOLE - PACKWOOD BILL SUMMARY

SUMMARY

Key Provisions of the Dole/Packwood Bill. The Dole/Packwood Bill includes three major initiatives:

- Health insurance market reform;
- Subsidies to low-income individuals; and
- Reductions in public program spending -- integration of Medicaid recipients into private plans, and Medicare cuts.

Based on preliminary analyses, this Bill could cover 89 to 90 percent of the U.S. population [NOTE: these are figures that we would NOT want to quote]. These reforms will be financed primarily by Medicare and Medicaid cuts, and state Medicaid maintenance of effort requirements. The Bill also includes a fail-safe mechanism to ensure that federal health care spending does not exceed budgeted levels.

Key Differences Between the Dole/Packwood and the Mitchell Bill. Under Dole/Packwood:

- No guarantee of universal coverage, and no target specified for expanded coverage;
- No Medicare drug benefit;
- Virtually no long-term care benefit enhancements;
- No incentives for employers to expand coverage to all workers;
- Subsidies phase out at 150 percent of poverty, providing no assistance to many low-income individuals and families;
- No private cost containment measures to address health care cost inflation or rate spikes.

BASIC PROVISIONS

1. HEALTH INSURANCE MARKET REFORM

Standard Benefits Package: All health plans would be required to make available a standard benefits package called FedMed. The FedMed package would include, at a minimum, Federal Employee Health Benefits Plan (FEHBP) benefits and benefits specified in the HMO Act of 1973. Health plans would determine the medical appropriateness of specific treatments and technologies. The Secretary would establish low, high, and moderate cost sharing arrangements for the FedMed plan, modeled after FEHBP cost sharing schedules.

Federal Employee Health Benefits Plan (FEHBP): Self-employed individuals and small employers (1 to 50 employees) would be permitted to purchase health plans offered through the FEHBP.

Modified Community Rating: There would be two market segments: individuals in small groups (1 to 50), and large groups (including associations and MEWAs). Age rating would be required in the small group market. Allowed rate variation based on age would be limited (4:1 rate bands for the first three years after implementation; 3:1 thereafter). Both small and large groups could self-insure.

Pre-Existing Conditions Exclusions: Conditions diagnosed or treated during the three months prior to coverage could be excluded for six months. No other pre-existing condition exclusions would be allowed.

Guaranteed Issue and Renewal: Health plans would be required to accept and renew anyone seeking coverage.

Risk Adjustment: States would risk-adjust (1) community-rated health plans, and (2) reinsurers of health plans for small employers who self insure.

Medical Savings Accounts (MSA's): The Bill establishes incentives for individuals to establish Medical Savings Accounts -- employer contributions would be excluded from employee's income and could be deducted from the employer's income.

Long-Term Care Insurance Reform: The Bill would establish specified provisions of the NAIC Model Act and Regulations as standards for long-term care insurance. Policies which meet these standards would be eligible for favorable tax treatment.

2. **SUBSIDIES TO LOW-INCOME INDIVIDUALS**

Subsidies would be available to low income individuals and families (up to 150% of poverty) if they are not covered by an employer or public program. A worker who is offered employee-only coverage by his/her employer may choose either the employer coverage or subsidized family coverage.

Subsidy amounts would be determined based on the standard benefit package (the FedMed package). The maximum subsidy would equal the base used for calculating the maximum federal contribution for FEHBP coverage, adjusted for age and geography.

Individuals and families with income below 100% of poverty would be eligible to receive the full subsidy, and those with income between 100% and 150% of poverty would be eligible to receive partial subsidies on a sliding scale basis. Subsidy payment amounts would be reduced if the cost of federal health programs, including subsidies, exceeds a targeted amount (see Fail Safe Mechanism, below).

3. **PUBLIC PROGRAM REDUCTIONS**

Medicare: Medicare would remain a separate program, but with no benefits

improvements. Within one year of enactment, the Secretary of the Department of Health and Human Services would make recommendations to Congress regarding (1) allowing Medicare beneficiaries to enroll in private health plans; (2) allowing Medicare beneficiaries to establish Medical Savings Accounts; (3) allowing certain military retirees to enroll in Federal health programs.

The methods by which HMOs' and other risk contractors' payment rates are set would be significantly revised. HMOs would be permitted to "lock-in" beneficiaries for up to one year. "Medicare Select" would be established as a standard MediGap plan.

Medicaid:

- Covered Populations: States would be required to integrate all AFDC and non-cash recipients into the premium assistance program for certified health plans by January 1, 2000. AFDC families would be eligible to receive full premium subsidies.

States would have the option to integrate SSI recipients into certified health plans, on a phased-in basis. States would be given greater flexibility to administer their Medicaid programs for SSI recipients who remain in Medicaid.

- State and Federal Payments:

Federal Payments: Federal matching payment for Medicaid eligibles integrated into the premium assistance program would be limited to the Federal share at FMAP rates of the average premium for all certified health plan enrollees (except SSI enrollees).

State Payments: States would not be required to make payments above the state share of the average premium for all certified health plan enrollees.

States would be required to contribute state Maintenance of Effort Payments.

- Supplemental Benefits (Wrap-Around Services): States would maintain current services for all eligibles under the States' plans. These expenditures would be based on FMAP but capped at a fixed sum (\$12 billion in FY 1997) and indexed to inflation.
- Disproportionate Share Payments (DSH): Effective January 1, 1997, the national limit on DSH payments would be lowered to 9 percent, and allotments for high DSH states would be reduced to 75 percent of the current state-based allotment.

FINANCING**1. Medicare:**

Medicare savings would be achieved through a series of cuts, including:

- reductions in the PPS hospital update;
- revisions to the DSH adjustment;
- changing the method of updating payments to physicians;
- repealing the limit on maximum rate reductions for payments to physicians.

Draft preliminary estimates indicate the Medicare provisions savings would save:

- \$39.0 billion between FY 1995 to FY 2000;
- \$142 billion between FY 1995 and FY 2004.

2. Medicaid:

Federal Medicaid savings would be achieved due to:

- discontinued coverage of acute care services for the AFDC and non-cash groups integrated into the premium assistance program;
- limits on Federal payments for supplemental benefits and DSH;
- state maintenance of effort requirement for the states' share of expenditures for acute care services for the AFDC and non-cash groups integrated into the premium assistance program.

3. Fail-Safe Mechanism:

If the cost of Federal health programs, including subsidies, exceeds a target amount, then the subsidies are to be cut back by: (1) reducing the number of people receiving subsidies, and (2) by reducing the subsidy amounts.

June 11, 1996

TRENDS IN HEALTH SPENDING BY THE PRIVATE SECTOR AND MEDICARE

INTRODUCTION

Recent evidence from a variety of sources--the national health accounts (NHA), surveys of private employers, and the experience of large groups of employees--suggests that the growth in private health expenditures has slowed considerably in recent years, continuing at least through 1995. That decline has given rise to questions about the likely future growth of private health spending. It has also raised concerns about the comparative performance of the Medicare program, in which spending continues to increase rapidly. This memorandum explores those issues.

CBO'S PROJECTIONS OF NATIONAL HEALTH EXPENDITURES

The Congressional Budget Office's (CBO's) most recent projections of national health spending were distributed to the Congress in early 1995 and subsequently published as an appendix to *The Economic and Budget Outlook: An Update* (August 1995). Those projections assumed that total private spending for health insurance (including employment-based plans, individually purchased insurance, and medigap coverage) would grow by about 5 percent in 1994, 6 percent in 1995, and 7 percent in 1996. The projected growth rate for private health insurance premiums and benefits averaged about 7 percent a year over the 1995-2005 period.

The latest indicators of trends in private-sector premiums, however, suggest that CBO's projections of 6 percent growth in 1995 and 7 percent growth in 1996 may have been too high. Information from surveys of employers, as well as the experience of several major groups of public employees, suggests that premiums actually grew more slowly in 1995 than in 1994, not more rapidly as CBO's earlier projections assumed (see Table 1). Although they are not without their limitations, those indicators suggest a continuing decline in employers' health insurance costs (see Appendix A).

CBO plans to update its projections of national health expenditures later this year and, in the light of the 1995 data, is likely to lower its private-sector estimates for 1995 and 1996. At present, however, it is too early to conclude that the longer-term growth rates should be lowered. CBO's projections of private health expenditures are based on the assumption that continuing competitiveness in health insurance

markets will determine future growth in private health insurance spending. In the first half of the 1990s, that growth was slowed through a combination of aggressive private purchasers seeking better deals for their health care dollars and the growth of managed care plans that could compete effectively on price. CBO assumes that the resulting price competition among health plans and providers will continue in the future. Although premiums are likely to grow somewhat more rapidly than in the past two years, growth rates are unlikely to return to the high levels of the 1980s, when private health insurance spending increased at an average rate of almost 13 percent a year.

COMPARING THE PRIVATE SECTOR AND MEDICARE

Unlike private health expenditures, Medicare spending has continued to grow rapidly in the 1990s. That difference represents a marked change from the 1980s, when private and Medicare expenditures grew at similar average annual rates (see Figure 1, which shows growth in total payments for benefits). According to the NHA, while the annual growth in private health insurance expenditures fell from about 14 percent in 1990 to less than 6 percent in 1994, Medicare spending continued to grow at double-digit rates.

It is hardly surprising that the growth in private-sector health spending appears to have slowed significantly but the growth in Medicare spending has not. In the 1980s, Medicare and most private health plans generally paid claims based on providers' costs or charges, creating no incentives to control costs. Recent changes in private health insurance markets, however, have resulted in aggressive competition among private plans and corresponding efforts to constrain premium increases as plans compete for shares of the health insurance market. By contrast, competition still plays only a minor role in the Medicare market, and approximately 90 percent of Medicare beneficiaries are still enrolled in the traditional fee-for-service program. Moreover, Medicare payments on behalf of beneficiaries enrolled in managed care plans are directly tied to fee-for-service payments. Those differences in spending growth and market structure inevitably raise questions about whether Medicare could improve its performance by adopting private-sector innovations.

Precise comparisons of spending growth rates between Medicare and the private sector are difficult to make, however, and erroneous inferences are hard to avoid. Comparisons of the growth in total expenditures, for example, are problematic because of differing trends in the number and type of people covered by private insurance and Medicare. While the Medicare population increased steadily

**THE DOLE BILL WOULD INCREASE THE DEFICIT
BY OVER \$150 BILLION**

The Dole Bill cuts Medicaid and Medicare--without increasing benefits for seniors--and provides subsidies for the poor and increased health insurance tax deductions for the self-employed and other individuals.

**THE DOLE BILL WOULD INCREASE THE DEFICIT BY OVER \$150 BILLION
FROM 1995 TO 2004**

- The Dole Bill creates a new entitlement to states for supplemental benefits, but does not raise enough money to pay for it.
- The Dole Bill also provides increased health insurance tax deductions for the self-employed and other individuals, but does not raise enough money to pay for them either.
- **Overall, the Dole Bill would increase the federal deficit by over \$40 billion from 1995 to 1999, and by over \$150 billion from 1995 to 2004.**
- In contrast, CBO's analysis of the Mitchell Bill concludes that it would cover 95% of Americans, while at the same time achieving long-term deficit reduction that grows over time.

**THE DOLE BILL HAS INSUFFICIENT FINANCING TO PAY FOR WHAT IT
PROMISES**

- In addition to increasing the deficit, the Dole Bill makes promises of subsidies to low-income people up to 150% of the poverty level that it can't pay for--and consequently can't keep.
- In fact, the Dole Bill only raises enough money to subsidize Medicaid recipients plus others with income up to 75% to 80% of the poverty level--that's about \$11,000 a year for a family of four.
- So while the Mitchell Bill provides help to all of the poor, to middle-income children, and to workers who lose their jobs, the Dole Bill does not even provide assistance to all those who are truly poor.

HEALTH CARE WAR ROOM

ROUTING SLIP

DATE: 8/22

WHITE HOUSE STAFF

Senate - Mitchell
 CAPITOL HILL

CABINET

GROUPS

OTHER

BINDER ONLY

COMMENTS:

READER'S GUIDE TO THE DOLE BILL

TITLE I -- AFFORDABLE HEALTH INSURANCE COVERAGE

Sec. 101 Tax Deductions for Self-Insured and People Buying Their Own Insurance

Individuals not eligible for employer-subsidized coverage, either directly or through their spouse's or dependents' employer, will be able to deduct from their taxes the amount they spend on premiums.

The tax deduction is phased in -- 25% in 1994/95; 50% in 1996/97; 75% in 1998/99.

Sec. 111/220 Tax Deductions for Medical Savings Accounts

Eligible individuals and families can contribute up to \$2,000 (\$4,000 for a family) tax free to medical savings accounts, if: 1) they have a high deductible plan, 2) their employer doesn't contribute to their insurance or to a medical savings account established for them.

The tax deduction is phased in -- 25% in 1994/95; 50% in 1996/97; 75% in 1998/99.

Sec. 112 Employer Contributions to Medical Savings Accounts

Contributions employers make to medical savings accounts are excluded as income for employees. (The employees must have high-deductible health plans) The tax excludable amounts are the same as above.

SUBTITLE B -- PREMIUM ASSISTANCE

TITLE II - HEALTH INSURANCE AND DELIVERY SYSTEM REFORM

TITLE XXI - STATE PLAN FOR CERTIFICATION OF HEALTH INSURANCE AND DELIVERY SYSTEMS

Sec. 21012 - Consumers shall have available comparative information on the performance of all health plans in their area, to help make decisions about which plan is best. [p.60] (CH: need to compare to Mitchell)

Sec. 21013 - Each state will set up community rating areas (1 or more) to cover the whole state, none of which may cover an area with fewer than 250,000 residents and none of which may be overlapping. [p.61]

Sec. 21014 - Each state will set up a risk adjustment program. [p 62] (see Sec. 21104)

Thus: This maintains the status quo, in which some states have chosen to form purchasing alliances, but some have not. Small businesses and individuals *might* have the opportunity to purchasing power and get the best rates, or they *might not*. They have no guarantee that a purchasing cooperative will be available. Even, if one is available, only small businesses with fewer than 50 employees and individuals are allowed to join. This leaves mid-sized businesses with more than 50 employees in the worst position -- too large to join a purchasing cooperative and too small to self-insure.

In contrast, the Mitchell proposal requires that voluntary purchasing cooperatives be formed and that employees of small businesses be given the opportunity -- but not required -- to purchase community-rated insurance through them.

Sec. 21211 Small Business Participation in FEHBP

- Small business with fewer than 50 employees are allowed to purchase insurance through the Federal Employees Benefit Program [FEHBP].

But: The Mitchell proposal wants to ensure millions more Americans that they will have the same health care that members of Congress get. Employees in firms smaller than 500 are given the option of purchasing insurance through the FEHBP. The Senate bill also guarantees that individuals purchasing insurance on their own, who are faced with the very highest rates in today's market, will have a wide range of affordable health plans through the FEHBP. The Dole plan does not.

TITLE V - HEALTH CARE PROVIDERS

Subtitle A - Education and Research

Section 501 -- Advisory Commission on Workforce

- Creates an Advisory Commission on Workforce made up of experts in medical education, the operation of teaching hospitals, and the operation of health plans. The Commission, appointed by OTA, would provide analysis and recommendations to Congress on physician training and graduate medical education payment policy.

(Unlike the Mitchell bill, the Advisory Commission established in the Dole bill can make recommendations only).

Section 502 -- Graduate Medical Education Consortium Demonstration Projects

- Establishes limited demonstration project for primary care consortia to test methods of increasing the number and percentage of medical students entering primary care practice.

(Unlike the Mitchell bill, the Dole bill, with no allocation system, would not guarantee an increase in the number of primary care physicians nationwide).

(Unlike the Mitchell bill, the Dole bill does not provide additional support for training advance practice nurses)

Section 503 -- Funding Under Medicare for training in NonHospital-Owned Facilities

- Provides that residency training in nonhospital-owned facilities is counted in determining full-time equivalent residents for Medicare GME payments

(Unlike the Mitchell bill, the Dole bill does not provide increased financial support to assure the survival of academic health centers as the market becomes increasingly dominated by managed care).