

**DRAFT**

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**COMMITTEE ON FINANCE**

**CHAIRMAN'S MARK**

**HEALTH SECURITY ACT OF 1994**

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## HEALTH SECURITY ACT OF 1994

### **I. INSURANCE REFORM STANDARDS**

#### **A. REQUIREMENTS FOR INSURED HEALTH PLANS**

##### Present Law

Federal law generally does not govern the sale of insured health plans to individuals or groups. The two exceptions are Title XVIII of the Social Security Act that regulates the sale of supplemental Medicare policies (Medigap policies) and Title XIII of the Public Health Service Act which sets out standards (including benefit package and rating) for health maintenance organizations that choose to be federally qualified. States set standards for insurance policies and many States have enacted insurance reforms in the past three years.

##### Description of Proposal

#### **1. State Responsibilities**

Participating States would be required to certify that primary insurance coverage offered for sale by commercial insurance companies, Blue Cross plans, integrated health plans, and other organizations that assume health insurance risks ("insured health plans") comply with new Federal standards. Federal Medicaid matching payments would not be available to non-participating States. Federal low-income premium subsidies could only be paid for individuals enrolled in State-certified standard insured health plans.

Insured health plans not meeting standards for certification would be subject to a civil monetary penalty not to exceed 50 percent of gross premiums during the period in which the violations occurred.

#### **2. Guaranteed Issue**

Insured health plans would be required to accept all individuals and their dependents, and all groups that apply for coverage. Insured health plans could not deny coverage based on health status, medical condition, claims experience, receipt of health care, medical history, anticipated need for health care services, disability, or lack of evidence of insurability.

Insured health plans would be required to issue coverage to individuals or groups except when (i) the health plan demonstrates that such enrollment would cause it to exceed service capacity or (ii) the individual or group has not requested enrollment during the open enrollment period. Each health plan would be required to have at least one annual

open enrollment period of 30 days. Enrollment in a health plan outside the open enrollment period would be permitted without penalty under a limited set of circumstances including marriage, court order, and change in employment status.

Subject to Part V, insured health plans would be required to offer coverage through all purchasing cooperatives in a community rating area, and would be required to sell outside the cooperatives.

An exception to the guaranteed issue rule would be made for religious fraternal benefit societies that were in existence as of September 1993, which bore the risk of providing insurance to their members, and which receive tax-exempt status under Sec. 501(c)(8) of the Internal Revenue Code.

**Effective Date**

January 1, 1996.

**3. Extended Coverage of Dependents**

Insured health plans would be required to offer family coverage that includes coverage of dependent unmarried children up to age 24 and spouses.

**Effective Date**

For policies issued or renewed on or after January 1, 1996.

**4. Guaranteed Renewal**

Insured health plans would be prohibited from terminating or otherwise failing to renew coverage for groups or individuals except in the case of 1) nonpayment of premiums; 2) fraud on the part of the policyholder or purchaser; or 3) misrepresentation by the policyholder or purchaser on an application for coverage or claim for benefits.

**Effective Date**

For policies in effect on or after June 28, 1994.

**5. Limits on Pre-Existing Condition Exclusions (Portability)**

a. Insured health plans could not exclude coverage of treatment for a pre-existing condition for more than 6 months from date of plan enrollment. A condition is pre-existing if it was treated or diagnosed in the 6 months prior to the date of enrollment. Insured health plans could not apply exclusions if individuals were recently insured by another health plan. Insured health plans could not apply pre-existing condition limitations to newborn coverage and would be required to offer automatic coverage of newborns on the parent's policy.

**Effective Date**

For policies issued on or after January 1, 1996.

b. Insured health plans could exclude from coverage only a condition that was treated or diagnosed in the 3 months prior to enrollment. Insured health plans could not limit coverage when the pre-existing condition is pregnancy.

**Effective Date**

For policies issued on or after January 1, 1997.

**6. One-Time Amnesty for Pre-Existing Conditions**

Insured health plans would be required to enroll, without pre-existing condition limitations, any uninsured person who applies for enrollment. This one-time amnesty would be effective only during the first open enrollment period after the effective date of this section.

**Effective Date**

For the first open enrollment period beginning on or after January 1, 1996.

**7. Standardized Benefit Package**

Insured health plans would be required to offer a standardized benefit package as a separate package, in conformance with other requirements of the legislation.

**Effective Date**

For policies issued or renewed on or after January 1, 1996.

**8. Modified Community Rating**

a. States would be directed to establish geographic areas ("community rating areas") within which insured health plans would be required to community rate. Each State would determine the number of such areas within it. However, a community rating area could not subdivide a Metropolitan Statistical Area (MSA) and must contain at least 250,000 individuals. In establishing a community rating area, States could not discriminate on the basis of health status or the perceived need for health services. MSAs that cross State boundaries could be treated as one community rating area if both States agree to cooperate.

b. The community-rated market would include all eligible individuals who are not (i) employees (and their dependents) of an employer with 500 or more employees (other than an employer whose primary business is employee leasing); or (ii) participants in a Taft-Hartley plan, rural cooperative plan, or multiple employer welfare arrangement (MEWA) grandfathered under

section C.2 of this Part.

c. Insured health plans selling policies in the community-rated market would be permitted to offer only policies that are community rated, modified for the location of the community rating area, family size, and age. The age adjustment would be limited so that the ratio between the highest and the lowest rate within a family class in a given geographic area could not exceed 2:1 for the population under age 65. The Secretary of HHS would consult with the National Association of Insurance Commissioners to develop uniform age categories and rating increments within 6 months of enactment.

d. Employer discounts for certain workplace wellness activities would be permitted.

**Effective Date**

For policies issued or renewed on or after January 1, 1996.

**9. Risk Adjustment**

a. The Secretary of HHS would be required to develop a risk adjustment mechanism that States would implement. All insured health plans in the community-rated market (inside and outside the purchasing cooperatives) would be required to participate. The risk adjustment mechanism would account for differences in the demographics, health status, and poverty and subsidy status of plan enrollees.

b. The Secretary of HHS would be required to develop, and States would be required to implement, a separate adjustment mechanism to redistribute losses among insured health plans resulting from the reduced cost sharing obligations of persons receiving subsidies, which must be absorbed by individual insured health plans as described in Part III (Subsidies).

c. States would also be required to operate reinsurance pools which meet Federal requirements until a risk adjustment mechanism is developed and implemented.

d. Nothing would prevent a reinsurance system and risk adjustment system from operating concurrently if the Secretary determines this is desirable.

**Effective Date**

States would be required to establish reinsurance pools by January 1, 1996, and implement a risk adjustment mechanism by January 1, 1997. States would be required to implement a cost-sharing subsidy redistribution system by January 1, 1997.

## 10. Exit from the Market

During the transition to community rating, insured health plans could terminate coverage of individuals or employers with fewer than 100 employees only if they terminate coverage for all such individuals or groups in the State (or terminate coverage in both these markets if the health plan operates in both markets) and would then be prohibited from re-entering the market(s) in the State for five years.

### Effective Date

Effective upon enactment until January 1, 1996.

## B. REQUIREMENTS FOR SELF-INSURED HEALTH PLANS

### Present Law

The Federal government regulates employment-based health plans under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA requires reporting and disclosure of certain information to the Department of Labor (DOL) and imposes fiduciary responsibilities on plan sponsors.

### Description of Proposal

#### 1. Federal and State Responsibilities

a. Participating States would be required to certify self-insured plans that operate in only one State. The Secretary of Labor would be required to certify multistate self-insured plans.

b. Self-insured plans that are not certified as satisfying the following requirements would be subject to a civil monetary penalty not to exceed 50 percent of gross health plan expenditures during the period in which the violations occurred.

#### 2. Guaranteed Issue

Self-insured health plans could not deny coverage or vary premiums based on health status, medical condition, claims experience, receipt of health care, medical history, anticipated need for health services, disability, or lack of evidence of insurability.

### Effective Date

January 1, 1995.

#### 3. Guaranteed Renewal

Self-insured plans could not terminate or otherwise fail to renew an individual's coverage due to the individual's health status, medical condition, claims experience, receipt of health care, medical history, or

lack of evidence of insurability.

**Effective Date**

June 28, 1994.

**4. Extended Coverage of Dependents**

Self-insured health plans would be required to offer family coverage that includes coverage of dependent unmarried children up to age 24 and spouses.

**Effective Date**

January 1, 1996.

**5. Limits on Benefit Reductions**

Self-insured plans could not reduce or limit coverage for any condition or course of treatment for which the anticipated cost for an individual is likely to exceed \$5000 in any 12-month period. Any such modification would not be effective and the self-insured sponsor would be required to provide benefits as though the modification had not occurred.

**Effective Date**

June 28, 1994 until January 1, 1996.

**6. Limits on Pre-Existing Condition Exclusions (Portability)**

a. Self-insured plans could not exclude from coverage, for more than 6 months from the date of plan enrollment, treatment of a pre-existing condition. A condition is pre-existing if it was treated or diagnosed in the 6 months prior to the date of enrollment. Self-insured plans could not apply exclusions if individuals were recently insured by another health plan, nor could plans apply pre-existing condition limitations to newborn coverage. Plans would be required to offer automatic coverage of newborns on a parent's policy.

**Effective Date**

January 1, 1996.

b. Self-insured plans could only exclude from coverage a condition that was treated or diagnosed in the 3 months prior to enrollment. Plans could not limit coverage when the pre-existing condition is pregnancy.

**Effective Date**

January 1, 1997.

## 7. One-Time Amnesty for Pre-Existing Conditions

Self-insured plans would be required to enroll, without pre-existing condition limitations, any group member who is otherwise eligible for coverage. This one-time amnesty would be effective only during the first open enrollment period under reform.

### Effective Date

The first open enrollment period beginning on or after January 1, 1996.

## 8. Standardized Benefit Package

Self-insured plans must provide a standardized benefit package as a separate package, in conformance with other requirements of the legislation. Plans could provide additional benefits through certified supplemental policies.

### Effective Date

Effective for new coverage or renewals beginning on or after January 1, 1996.

## C. REQUIREMENTS FOR EMPLOYERS

### Present Law

No provision.

### Description of Proposal

#### 1. Employer Responsibility to Make Insurance Available

##### a. Employers in the community-rated market

Any employer in the community-rated market would be required to make payroll deductions for health insurance for each employee that requests it. These employers would be required to make available at least three certified standard health plans in the community-rated pool, including a fee-for-service option and a point of service option. An employer in this market would be permitted to meet this requirement by offering coverage through a purchasing cooperative that offers at least three types of certified standard health plans at the community rate.

##### b. Other employers

Employers not in the community-rated market would be required to make payroll deductions for employees who request it. These employers would be required to make available at least three types of certified standard health plans, including a fee-for-service plan and a point of service

option. These employers would not be permitted to purchase health plan coverage in the community-rated market.

**c. Enforcement**

A civil monetary penalty would be assessed on employers for failure to comply with any of the preceding requirements. The penalty would not exceed 25 percent of the wages of affected employees during the period in which the violation occurred.

**Effective Date**

January 1, 1996.

**2. Employers that are Permitted to Self-Insure**

Only employers and organizations described in one of the following categories would be permitted to sponsor a self-insured or experience-rated health plan:

- (a) Employers (other than employers whose primary business is employee leasing) with 500 or more employees;
- (b) Grandfathered Taft-Hartley or rural cooperative plans; and
- (c) Grandfathered multiple employer welfare arrangements (MEWAs).

Existing Taft-Hartley and rural electric and telephone cooperative health plans with at least 500 participants would be permitted to self-insure or purchase experience-rated insurance. MEWAs in existence as of January 1, 1991 that are maintained by a bona fide group or association of employers or by an employee organization and that covered at least 1000 participants as of June 1, 1994 also would be permitted to continue to provide health care coverage. However, grandfathered MEWAs (1) could not self-insure, (2) could not increase the number of participants covered under the arrangement by more than 5 percent, and (3) would be subject to new, more stringent, Federal standards. (Two or more employers with 500 or more employees who form a MEWA would not be subject to these MEWA rules.)

**Effective Date**

January 1, 1996.

**D. ANTITRUST REFORM**

**Present Law**

The McCarran-Ferguson Act (15 U.S.C. §§1011-15) provides that the "business of insurance" is exempt from Federal antitrust laws, provided that such business is regulated by the State and that the challenged

actions do not constitute a boycott or coercion or intimidation.

Description of Proposal

Immunity from antitrust suits under the McCarran-Ferguson Act with respect to health insurance would be repealed. This would not alter immunity with respect to other forms of insurance.

**Effective Date**

Effective for causes of action arising on or after January 1, 1996.

## II. COVERAGE

### Present Law

No provision.

### Description of Proposal

#### A. COVERAGE GOAL

Universal health care coverage is the national goal of this legislation. An individual is "covered" if insured by a certified standard or very high deductible health plan, or by one of the following public plans: Medicare, Medicaid, a Department of Defense health program, a Department of Veterans Affairs health program or an Indian Health Service program.

#### B. NATIONAL HEALTH CARE COMMISSION

An independent National Health Care Commission would be established to monitor and respond to: (1) trends in health insurance coverage; and (2) changes in per-capita premiums and other indicators of health care inflation.

The Commission would be composed of 7 members nominated by the President and confirmed by the Senate. Commissioners would serve 6-year, staggered terms. No more than four members of the Commission may be from the same political party.

#### C. DETERMINATION BY COMMISSION

If the Commission determines that specified coverage goals (described in paragraph D) have not been achieved an employer mandate would automatically be triggered requiring employers to contribute 80 percent of the cost of a certified standard health plan.

**D. EMPLOYERS SUBJECT TO HARD TRIGGER**

**FIRMS WITH 100 OR MORE EMPLOYEES:** three years after enactment, if market reforms in a voluntary system do not result in 85 percent of the currently uninsured employees of firms in this category gaining coverage, a mandate would go into effect.

Percent of employees in this category who are currently  
uninsured.....11 percent  
Number of uninsured employees in the category .....7.4 million

(85 percent of 7.4 million = 6.3 million)

Percent of all firms.....1.6  
Percent of all employees.....60.8

**FIRMS WITH 25 TO 99 EMPLOYEES:** four years after enactment, if market reforms in a voluntary system do not result in 80 percent of the currently uninsured employees of firms in this category gaining coverage, a mandate would go into effect.

Percent of employees in this category who are currently  
uninsured.....21 percent  
Number of uninsured employees in this category.....3.3 million

(80 percent of 3.3 million = 2.6 million)

Percent of all firms.....6.5  
Percent of all employees.....15.9

**FIRMS WITH FEWER THAN 25 EMPLOYEES:** five years after enactment, if market reforms in a voluntary system do not result in 75 percent of the currently uninsured employees of firms in this category gaining coverage, a mandate would go into effect.

Percent of employees in this category who are currently  
uninsured.....26 percent  
Number of uninsured employees in this category.....9.8 million

(75 percent of 9.8 million = 7.4 million)

Percent of all firms.....91.9  
Percent of all employees.....23.0

#### **E: ONGOING MONITORING**

The Commission will provide on-going review of coverage rates. If at anytime after the initial determination of whether coverage goals were met for the group of firms described in paragraph C, the Commission determines that coverage has fallen below the specified goals, then the mandate for that group of firms would automatically be triggered.

#### **F. INSURANCE ADJUSTMENTS**

If a mandate goes into effect for all firms, insurance reform standards would be adjusted as follows:

1. **Guaranteed Issue:** Health plans would be required to provide unrestricted open health plan enrollment.

2. **Pre-Existing Condition Limitations:** Health plans would be prohibited from applying any pre-existing condition limitations.

#### **G. ENFORCEMENT PENALTIES**

Any employer that fails to comply with the mandate would be subject to an excise tax equal to \$100 for each day for each employee for whom the employer has failed to provide coverage.

**Effective Date**

Upon enactment.

### III. SUBSIDIES

#### A. PREMIUM SUBSIDIES

##### Present Law

No provision.

##### Description of Proposal

#### 1. Eligibility

Subsidies are payable according to the following criteria:

(a) full subsidy for individuals and families with income that does not exceed 100 percent of poverty; beginning in 1997, the subsidy is phased out for those with income between 100 percent and the following percentages of poverty:

Calendar Year	Percentage of Poverty
1997	125
1998	150
1999	175
2000	200

(b) the benefit package to be subsidized is limited to the value of a certified standard health plan;

(c) no subsidy is payable for those entitled to a subsidy of \$150 or less; and

(d) there is no poverty adjustment for family size above a family size of 4.

Resident citizens and aliens permanently residing in the U. S. under color of law are eligible for a subsidy for the purchase of a certified standard health plan. Undocumented aliens are not eligible.

The poverty level that will be used in determining eligibility is the official poverty line as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981.

#### 2. Subsidy value

The full subsidy will equal the cost of the premium for a certified standard health plan, but no higher than the average cost of such a plan in the community rating area minus the amount of any contribution offered by an employer.

### **3. Definition of income**

Income is defined as adjusted gross income (as determined for purposes of paying Federal income taxes), modified to include nontaxable interest income, the portion of social security benefits that are not subject to taxation, and welfare payments.

### **4. Subsidies for AFDC recipients**

Recipients of AFDC who are integrated into the reformed health care system are eligible for subsidies on the same basis as all other eligible individuals. Individuals may file an application for a premium subsidy at the same time that they apply for AFDC.

### **5. Eligibility determination**

The Secretary of Health and Human Services is directed to promulgate regulations specifying procedural requirements that States must follow in determining eligibility for subsidies, which shall include regulations relating to procedures for filing of applications, verification of information, timeliness of decision-making, appeals of adverse decisions, and such other matters as the Secretary determines to be necessary. Outreach activities by Federal and State governments will be required.

Eligibility will be calculated on an annual basis. An individual or family that has an approved application for a subsidy must file an end-of-year income reconciliation statement at such time as is specified in regulations. Failure to file a reconciliation statement will result in ineligibility for subsidies until the statement is filed, unless there is good cause.

The Secretary of the Treasury in consultation with the Secretary of Health and Human Services shall promulgate regulations providing for the use of income tax return information in determining and verifying eligibility to the extent practicable.

The agency administering the subsidy program shall pay the subsidy to which an individual or family is entitled directly to the plan in which the individual or family is enrolled. An employer of an employee whose application for a subsidy has been approved must, upon request of the employee, adjust any premium amount being withheld on behalf of the employee to reflect the premium subsidy for which the employee is eligible.

An individual who knowingly understates income in an application for a subsidy shall be liable for any excess payments made based on the understatement and for interest. An individual who knowingly misrepresents material information shall be liable for \$2,000 or, if greater, three times the excess payments made based on the misrepresentation.

### **6. Responsibility for administration**

The State shall be responsible for administration, and may designate

the public agency that it deems appropriate to carry out necessary functions. The Secretary of Health and Human Services must develop standards to assure consistency among States with respect to data processing systems, application forms, and such other administrative activities as the Secretary determines necessary to promote the efficient administration of the subsidy program. A State shall be liable to the Federal government for payments made in error.

Funds required to pay the subsidies will be transferred to the State at such time and in such form as provided in regulations. The Secretary of Health and Human Services shall provide for regular audits. A State shall be liable for payments made in error.

The Federal government will match State administrative costs at a rate of 75 percent Federal, 25 percent State.

#### **Effective Date**

States have the option of providing subsidies to those who are eligible beginning with the month of January 1996, and must provide subsidies for months after December 1996.

### **B. COST-SHARING SUBSIDIES**

#### **Present Law**

No provision.

#### **Description of Proposal**

##### **1. Cost-sharing for those up to poverty**

Individuals and families eligible for a full subsidy (up to 100 percent of poverty) are eligible for reduced cost-sharing at point of service, as determined by the National Health Benefits Board. The plan will absorb any short-fall.

#### **Effective Date**

Upon implementation of the State subsidy program.

##### **2. Cost-sharing for those above poverty**

States will have the option of providing subsidies for cost-sharing for individuals and families with income between 100 percent and 200 percent of poverty. The State would be required to pay 50 percent of the cost, and would be responsible for establishing eligibility requirements and for administration. Capped entitlement funds will be allocated to the States on the basis of State population, beginning in fiscal year 1997. Two billion dollars a year will be available for this purpose.

## C. SUBSIDIES FOR EMPLOYERS

### Present Law

No provision.

### Description of Proposal

#### 1. Eligibility

a. Employers will be eligible to receive subsidies if an employer mandate is triggered (as described under Part II).

b. Employers who are subject to the mandate are required to pay 80 percent of the cost of a certified standard health plan. In general, however, employer contributions for the 80 percent share of the premium are limited to no more than 12 percent of each employee's wage.

c. Subsidies are targeted to low-wage employees irrespective of where they are employed.

d. Although eligibility for the subsidy is based on the individual employee's wage irrespective of the average wage or firm size, the amount of the subsidy is based on firm size and the average wage of the firm. Contributions are limited to 5.5 - 12.0 percent of the wage of each employee within the firm in accordance with the following schedule:

Average Wage in Firm						
Firm Size	<12K	12-15K	15-18K	18-21K	21-24K	24K+
<26	5.5%	6.8%	8.1%	9.4%	10.7%	12.0%
26-50	6.8%	8.1%	9.4%	10.7%	12.0%	12.0%
51-75	8.1%	9.4%	10.7%	12.0%	12.0%	12.0%

e. If an employer mandate is triggered it will be implemented in accordance with a schedule described in Part II. Under this schedule, firms with fewer than 100 full-time equivalent employees are not immediately subject to the mandate. However, such firms would be eligible for subsidies, in accordance with the subsidy structure outlined in d. above, provided the firm contributed at least 50 percent to the cost of a certified standard health plan. When the mandate is phased in for these firms the subsidy would continue based on the 80 percent contribution required under the mandate.

#### 2. Definition of Wages

Wages are defined as in the Internal Revenue Code for the purpose of determining contributions for the Hospital Insurance Trust Fund. Wages will be defined equivalently for State and local governments that do not contribute to Social Security. In the case of a partner in a partnership, a 2-percent shareholder in an S corporation, or a sole proprietor, the individual's net earnings from self-employment are deemed to be wages.

**Effective Date**

This provision would be effective if an employer mandate is triggered under the provisions of Part II, on or after January 1, 2002.

**D. TRUST FUND FINANCING**

There is created in the Treasury a Health Security Trust Fund ("Trust Fund"). All subsidies required by this Act shall be paid from funds available in the Trust Fund, as would payments for infrastructure development for designated urban and rural areas (Part XII), and quality improvements.

Revenues attributable to the increase in excise taxes on tobacco products and other revenues raised by this Act would be deposited into the Trust Fund.

Amounts equivalent to the reductions in Federal Medicaid expenditures resulting from this Act, and State Maintenance of Effort payments required under this Act, would be deposited into the Trust Fund.

If Trust Fund obligations in a year exceed Trust Fund receipts, any shortfall would be automatically deposited into the Trust Fund from general revenues.

**Effective Date**

Upon enactment.

#### IV. BENEFITS AND THE NATIONAL HEALTH BENEFITS BOARD

##### A. VALUE AND STRUCTURE OF THE BENEFITS PACKAGE

###### Present Law

No provision.

###### Description of Proposal

The value of the standard benefit package would be based on the actuarial value of the Blue Cross/Blue Shield Standard Option (BC/BS-SO) under the Federal Employees Health Benefits (FEHB) program, adjusted for an average population. Fee-for-service plans would have an actuarial value equivalent to the BC/BS-SO under FEHB adjusted for an average population. Integrated plans could have reduced cost-sharing, set at a level to keep average premiums at, or below, the fee-for-service levels.

Cost sharing arrangements would include co-payments, co-insurance, and deductible amounts for services other than clinical preventive services. There would be three options for certified standard health plans:

1. Higher cost sharing plan would have an annual out-of-pocket maximum of \$2500 per individual or \$3000 per family; \$400 per individual or \$800 per family deductible; 25 percent co-insurance; \$250 per admission hospital deductible; \$250 prescription drug deductible.

2. Lower cost sharing plan, details of which would be specified by the National Health Benefits Board.

3. Combination cost sharing plan, in which an enrollee can choose any physician, but pay higher out-of-pocket costs for physicians who are not part of the network. Cost sharing details to be specified by the National Health Benefits Board.

In addition, a certified very high deductible health plan consisting of the same covered services with a \$5000 per individual or \$10,000 per family deductible would be available, but not as a certified standard health plan. (Only certified standard health plans can be offered by employers.)

##### B. COVERED SERVICES

###### Present Law

No provision.

###### Description of Proposal

Health plans would be required to offer a standardized set of covered services. Categories of covered services would be specified in statute. A

National Health Benefits Board would be directed to refine covered services by reference to standards of medical necessity or appropriateness. Medically necessary or appropriate treatments would be defined by law as those intended to maintain or improve the biological or psychological condition of the enrollee or to prevent or mitigate an adverse health outcome to the enrollee. For individuals under 22 years of age, the Board would be directed to give consideration to age and health status to prevent or ameliorate the effects of a condition, illness, injury or disorder, to aid in the individual's overall physical and mental growth and development, or assist the individual in achieving or maintaining maximum functional capacity.

Categories of covered services and equipment would include:

1. hospital services, including inpatient, outpatient, 24-hour a day hospital emergency, and hospital services provided for the treatment of a mental or substance abuse disorder. The definition of the term "hospital" would be the same as in Medicare, with additional reference to facilities of the uniformed services, Department of Veterans Affairs and Indian Health Service.
2. health professional services, including inpatient and outpatient services and supplies (including drugs and biologicals which cannot be self-administered). Health professional services means professional services that are lawfully provided by a physician or another person who is legally authorized to provide such services in the State in which the services are provided.
3. emergency and ambulatory medical and surgical services, including 24-hour a day emergency services, or ambulatory medical or surgical services.
4. clinical preventive services, including services for high risk populations, age-appropriate immunizations, tests, or clinician visits consistent with any periodicity schedule specified by the National Health Benefits Board. The National Health Benefits Board would be directed to consult with appropriate government agencies, task forces, and professional groups (for example, using recommendations of the Advisory Committee on Immunization Practices, the US Preventive Services Task Force, and for children, the American Academy of Pediatrics).
5. mental illness and substance abuse services. The Secretary of HHS would be directed to define such services so as to achieve parity with services for other medical conditions and would develop standards for the appropriate management of these benefits. Mental disorders and substance abuse disorders would be defined, respectively, as those listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition or revised version of such manual, or the equivalent listed in the International Classification of Diseases, 9th Revision, Clinical Modification, Third Edition or a revised version of such text.
6. family planning services and services for pregnant women,

including contraceptive drugs and devices dispensed by prescription and subject to approval by the Secretary of HHS under the Federal Food, Drug, and Cosmetic Act.

7. hospice care services, as defined in Medicare.

8. home health care services, as defined in Medicare with limitations such that these services would be an alternative to inpatient treatment in a hospital, skilled nursing facility or rehabilitation facility and would be reevaluated after each 60 day period. Covered services to include treatment as a result of an illness, injury, disorder or other health condition.

9. extended care services, as defined in Medicare when provided in inpatient skilled nursing facility or a rehabilitation facility as an alternative to inpatient hospital services to include treatment as a result of an illness, injury, disorder or other health condition.

10. ambulance services provided by ground, air or water transportation using equipment for transporting injured or sick individuals, only if indicated by the medical condition of the individual or in cases in which there is no other method of transportation or where use of other methods is contra-indicated by the medical condition.

11. outpatient laboratory, radiology and diagnostic services, provided upon prescription to individuals who are not inpatients of a hospital, hospice, skilled nursing facility, or rehabilitation facility.

12. outpatient prescription drugs, home infusion drug therapy and biologicals, including accessories and supplies used directly with drugs and biologicals, including any use approved by the Food and Drug Administration or if cited in the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluations, the United States Pharmacopoeia-Drug Information and other authoritative compendia as identified by the Secretary. Blood clotting factors would be defined as in Medicare. The Secretary of HHS may revise the list of compendia.

13. outpatient rehabilitation services, including outpatient occupational therapy; outpatient physical therapy; outpatient respiratory therapy; and outpatient speech-language pathology services and audiology services as a result of an illness, injury, disorder or other health condition. The need for continued services would be reevaluated at the end of each 60 day period by the person primarily responsible for providing the services.

14. durable medical equipment (DME), prosthetics and orthotic and prosthetic devices, including accessories and supplies necessary for repair, function and maintenance of DME. DME would be defined as in Medicare; prosthetic devices are devices that replace all or part of the function of a body organ including replacement of DME and prosthetic devices; orthotic devices are those accessories and supplies used directly with prosthetic devices to achieve therapeutic benefits and proper

functioning; orthotics are leg, arm, back, and neck braces; prosthetics are artificial legs, arms, and eyes including replacements if required; and fitting and training for use of these items.

15. vision care, hearing aids and dental care for individuals under 22 years of age including eyeglasses; contact lenses; emergency dental treatment for acute infections, bleeding and injuries to prevent risks to life or significant medical complications; prevention and diagnosis of dental disease including oral dental examinations, radiographs, dental sealants, fluoride application and dental prophylaxis; treatment of dental disease including routine fillings, prosthetics for congenital defects, periodontal maintenance and endodontic services; space maintenance procedures to prevent orthodontic complications and interceptive orthodontic treatment to prevent severe malocclusion.

16. investigational treatments, including routine care provided in research trials approved by the Secretary of HHS, the Directors of the National Institutes of Health, the Commissioner of the Food and Drug Administration, the Secretary of Veterans Affairs, the Secretary of Defense, or a qualified nongovernmental research entity as defined in guidelines of the National Institutes of Health, including guidelines for National Cancer Institute-designated cancer center support grants; or a peer-reviewed and approved research program as defined by the Secretary of HHS.

**Effective Date**

For all policies in effect on or after January 1, 1996.

**C. THE NATIONAL HEALTH BENEFITS BOARD**

Present Law

No provision.

Description of Proposal

A National Health Benefits Board would be established within the Department of Health and Human Services. The Board would consist of 7 members nominated by the President and confirmed by the Senate who would serve for six-year, staggered terms. No more than four members may be from the same political party.

The Board, in consultation with expert groups, would be authorized to promulgate regulations to: clarify covered services and cost-sharing, refine the statutory definition of medical necessity or appropriateness, develop appropriate schedules for covered services, and refine policies regarding coverage of investigational treatments.

The Board would also be authorized to issue regulations to modify the categories of covered services and cost sharing that would go into effect

unless Congress overturns the regulations by joint resolution considered under fast-track procedures.

**Effective Date**

Board members would be named by the President within 90 days after enactment.

## **V. HEALTH INSURANCE PURCHASING COOPERATIVES**

### **Present Law**

No provision.

### **Description of Proposal**

#### **A. VOLUNTARY PARTICIPATION IN COOPERATIVES**

No employer or individual would be required to purchase insurance through a health insurance purchasing cooperative. Individuals and employers eligible to purchase insurance through a cooperative could also elect to purchase insurance at modified community rates through a broker or directly from an insurance company.

#### **B. ELIGIBILITY TO PURCHASE INSURANCE THROUGH A COOPERATIVE**

All purchasers in the community-rated market would be eligible to purchase insurance through a cooperative. These include: (1) employers with fewer than 500 employees (and the individual employees of such employers); (2) self-employed individuals; (3) individuals not connected to the workforce; and (4) employers whose primary business is employee leasing. Eligible individuals could also purchase insurance on behalf of their dependents.

#### **C. COMPETING COOPERATIVES**

More than one cooperative could operate within a community rating area defined by the State under Federal standards. Cooperatives would not be required to contract with every certified health plan. If a cooperative negotiates a price lower than the community rate, that price becomes the health plan's community rate, which must be offered to all purchasers within the community rating area.

A cooperative would be permitted to serve more than one community rating area.

If a cooperative were not established in every community rating area by 1996, the State would be required to sponsor or establish a cooperative. In such cases, the State would only be required to sponsor or establish one cooperative that could serve all unserved areas within the State.

#### **D. RULES FOR COOPERATIVES**

Cooperatives would be required to accept all eligible individuals and employers in the community rating area they serve. Cooperatives would be required to ensure that their services were accessible in all parts of the community rating areas in which they operate. To ensure accessibility,

cooperatives would be authorized to make enrollment material available at designated public access sites, such as public libraries and local government offices.

Individuals not connected to the workforce would enroll in a cooperative based on residence.

Cooperatives would also be required to provide enrollees with a choice of at least three types of health plans, one of which must be a fee-for-service plan and one of which must be a plan that offers a point-of-service option. Governors could waive the requirement that cooperatives and employers offer a choice of at least three types of health plans in rural areas where the cooperative demonstrates to the Governor's satisfaction that there is insufficient population density to support three types of plans.

Cooperatives could require payroll deductions for employed individuals. Also, if employees ask their employers to make payroll deductions for a cooperative, employers would be required to comply.

Cooperatives would be prohibited from entering into contracts with health plans that are not certified.

#### **E. CHOICE OF HEALTH PLANS AND COOPERATIVES**

Enrollees, not employers, would choose a health plan within a cooperative. Employees of the same employer could choose different health plans within a cooperative.

Employers with fewer than 500 employees could choose a cooperative for their employees as an alternative to the requirement that they offer at least three types of health plans.

#### **F. GOVERNING STRUCTURE OF COOPERATIVES**

Cooperatives would be non-profit corporations governed by a board of directors elected by members of the cooperative. Units of State or local governments would be permitted to form a cooperative. Insurers would be prohibited from forming a cooperative, but would be permitted to administer one. Cooperatives would be eligible for Federal tax-exempt status (subject to rules concerning private inurement, lobbying and political activity restrictions).

#### **G. DUTIES OF COOPERATIVES**

Duties of cooperatives would include: entering into agreements with certified health plans, employers, and individuals; collecting and forwarding premiums to certified health plans; coordinating with other cooperatives; and providing a complaint process regarding cooperative actions. Cooperatives would be expressly prohibited from approving or enforcing provider payment rates, performing any activity relating to premium payment rates, and bearing insurance risk.

Cooperatives would be required to report to the State such information regarding marketing, enrollment and administrative expenses as required by the Secretary. The Secretary would be required to promulgate rules regarding fiduciary responsibilities of cooperatives.

#### **H. FEDERAL EMPLOYEES HEALTH BENEFITS (FEHB) PROGRAM**

All health plans participating in the Federal Employees Health Benefits Program would be required to offer coverage in the community-rated market in the areas in which they operate. Non-federal employee purchasers would pay the local community rate for that plan, and would not be a part of the FEHB insurance pool. Government-wide FEHB plans would not be required to open to non-federal employee enrollment.

#### **Effective Date**

January 1, 1996.

## **VI. COST CONTAINMENT**

### **A. PREMIUM TARGETS**

#### **Present Law**

No provision.

#### **Description of Proposal**

##### **1. National Health Care Commission**

The Commission (established under Part II of this document) would monitor the change in per-capita health insurance premiums for certified health plans.

##### **2. Premium Targets**

Targets for changes in per-capita premiums would be set in law as the projected percentage increase in the CPI-U, plus a percentage increment reflecting three factors: (1) increases in real per-capita income, (2) changes in demographics and health status indicators, and (3) changes in medical technology and the use of services. The premium targets' increments over CPI-U would be the following:

For 1996, 4.0 percentage points;  
For 1997, 3.5 percentage points;  
For 1998, 3.0 percentage points;  
For 1999, 2.5 percentage points;  
For 2000 and thereafter, 2.0 percentage points.

##### **3. Functions of Commission**

On February 15, 1997, and each February 15 thereafter through 2005, the Commission would report to the Congress and the President on the increase in per capita premiums. If the Commission finds that premiums during the prior calendar year increased at a rate in excess of the targets (adjusted to reflect the actual increase in the CPI-U), the Commission would be required to make appropriate recommendations to the Congress on measures to keep premium costs within the targets.

The Congress would be required to consider the recommendations of the Commission under expedited procedures. The proposals, upon transmittal to Congress, would be drafted as a joint resolution by House Legislative Counsel, in consultation with Senate Legislative Counsel, and would be introduced by the Majority Leaders of the Senate and House of Representatives, for themselves and the respective Minority Leaders by March 15. Committees would have 45 session days to report the resolution or be discharged. Committees may report amendments relevant to cost

containment. Three days after the measure is placed on the calendar, any Member could make a non-debatable motion to proceed to the resolution. Motions to proceed would be non-debatable. If the motion to proceed is agreed to, consideration of the resolution would proceed under a 50-hour time limitation and amendments relevant to cost containment would be in order. At the expiration of the 50 hours, a vote on final passage of the resolution would occur. Debate on conference agreements would be limited to 20 hours.

#### **Effective Date**

Upon enactment.

### **B. BUDGET CONTROL: PAY-AS-YOU-GO FAILSAFE**

#### **Present Law**

Congress enacted the Gramm-Rudman-Hollings Act (Pub. L. No. 99-177) in late 1985, to provide an incentive for the President and Congress to reduce the deficit each year through the regular legislative process. The Gramm-Rudman-Hollings Act established a declining series of deficit targets (referred to as "maximum deficit amounts") leading to a balanced budget in fiscal year 1991. The Act enforced the deficit targets by the "sequestration process," under which automatic spending reductions would occur if the projected deficit exceeded the deficit targets.

In 1987, after the Supreme Court ruled the sequestration triggering mechanism in the Gramm-Rudman-Hollings Act unconstitutional due to Legislative Branch involvement, Congress amended the Act, extending the goal of a balanced budget to fiscal year 1993 and placing responsibility for the automatic triggering of sequestration in the hands of the Director of the Office of Management and Budget (OMB).

Congress revised the sequestration process in the Budget Enforcement Act (BEA) of 1990. First, the Act extended the process through fiscal year 1995 (although the budget was not required to be balanced by that time). Second, the Act shifted the focus of deficit control away from overall deficit reduction targets, to a policy requiring that new Federal legislation not increase Federal deficits. This pay-as-you-go requirement was accomplished by establishing: (1) discretionary spending caps which effectively require that new or increased discretionary spending be offset by decreases in other discretionary programs; and (2) a pay-as-you-go (PAY-GO) requirement to ensure that legislative changes in entitlement spending and revenues are fully paid for. The BEA made the spending caps and PAY-GO requirement enforceable by sequestration (i.e. automatic budget reductions). Congress extended the spending caps and the PAY-GO requirement through fiscal year 1998 in the Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66.

The pay-as-you-go policy was strengthened in the FY 1994 and FY 1995 concurrent resolutions on the budget, which imposed a 10-year pay-as-you-go

requirement on entitlement and revenue legislation considered by the Senate. Legislation violating the requirement is subject to a point of order, which may only be waived by a supermajority of 60 votes.

The existing statutory PAY-GO constraints through FY 1998 and the Senate's 10-year pay-as-you-go point of order, operate to prevent the enactment of legislation which is projected at the time of enactment to cause increases in the deficit for any year through fiscal year 2004.

### Description of Proposal

This proposal would establish a mechanism for mid-course corrections in the event of increases in the deficit attributable to health care reform.

#### 1. Timetable for pay-as-you-go mechanism

**January/February** - In the years 1997, 1999, 2001, 2003 and 2005, five days prior to the President's budget submission, CBO is required to submit to the Congress and OMB a determination of whether health reform has caused an increase in the deficit in the prior year. Five days later, the President's Budget for the fiscal year is to include OMB's determination of whether health care reform caused a deficit increase in the prior fiscal year. OMB must explain any differences from CBO's preliminary determinations. If a deficit increase is attributed to health care reform, automatic and proportional reductions in: (1) subsidies and (2) the tax credit for insurance premiums paid by the self-employed and individuals not covered at work, go into effect September 20 unless alternative deficit reduction legislation is enacted prior to that time.

**June 1** - Deadline for the President to submit to the Congress an alternative deficit reduction resolution, which offsets the deficit increase attributable to health care reforms.

**June 10** - CBO to report to the Senate and House Budget Committees on whether the alternative deficit reduction resolution submitted by the President will produce the same amount of deficit reduction in the upcoming fiscal year as is required to be achieved through automatic reductions. If the Chairmen of the Senate and House Budget Committees certify that the alternative deficit reduction resolution produces the required deficit reduction, it is protected by fast-track procedures, as follows.

**June 15** - Deadline for the Majority Leaders of the House of Representatives and the Senate to introduce alternative deficit reduction legislation. Legislation to be referred to all relevant committees. Committees are to review the legislation, but no amendments are permitted.

**June 25** - House committees discharged of alternative deficit reduction legislation if they have not reported.

**July 1** - If no real economic growth in the two most recent quarters,

the Chairman of the Council of Economic Advisers is to make a "no-growth" report which suspends the subsidy reductions and congressional alternative deficit reduction fast-track.

**July 10** - Deadline for House of Representatives to vote on alternative deficit reduction legislation. Bill may not be amended; debate limited to 20 hours, equally divided.

**July 20** - Senate committees discharged if they have not reported bill received from the House.

**August 5** - Deadline for Senate vote on alternative deficit reduction legislation. Bill may not be amended; debate limited to 20 hours, equally divided.

**September 20** - If OMB made a determination in the President's budget that the deficit increased in the prior fiscal year due to health care reform, and if alternative deficit reduction legislation has not been enacted into law, then proportional reductions in: (1) subsidies and (2) the tax credit for insurance premiums paid by the self-employed and individuals not covered at work, go into effect.

**November 1** - GAO audit of automatic reductions, or implementation of alternative deficit reduction legislation, as the case may be.

**January/February** - CBO report to Congress on success of automatic reductions or alternative deficit reduction legislation in eliminating health care deficit.

**2. Entitlement to subsidies and certain tax deductions made contingent on automatic deficit reduction**

The legal entitlement to subsidies and the tax credit for insurance premiums paid by the self-employed and individuals not covered at work, would be subject to the operation of the back-up deficit reduction mechanism explained below.

**3. Preparation of "pre-health care reform baseline"**

CBO and OMB would be required, within 60 days following enactment, to prepare a baseline for total Federal health care expenditures, projected for each fiscal year through 2004, as would have occurred without the enactment of health care reform. CBO shall transmit its estimates to the Congress and OMB within 30 days of enactment. Five days after CBO's transmittal, OMB shall transmit to the Congress its determinations, explaining in detail any differences from CBO's estimates.

**4. Determination of deficit increase**

In calendar years 1997, 1999, 2001, 2003 and 2005, five days prior to the President's budget submission, CBO is required to submit to the Congress and the OMB estimates of whether health care reform has caused an increase in the deficit in the prior fiscal year. Five days later, the President's annual Budget for the upcoming fiscal year is to include OMB's determination of whether health care reform caused a deficit increase in the prior fiscal year. OMB must explain any differences from CBO's estimates.

In determining whether health care reform "has caused an increase in the deficit for the prior fiscal year," CBO and OMB shall proceed as follows:

a. Determine "total Federal health care spending for the prior fiscal year."

b. Adjust the "pre-health care reform baseline" for Federal spending in the prior fiscal year to reflect all identifiable health care spending variables not attributable to health care reform.

c. Subtract pre-health care reform spending for the prior fiscal year (as adjusted), from total Federal health care spending for the prior fiscal year--producing the "net increase in Federal health care spending for the prior fiscal year."

d. Subtract from the net increase in Federal health care spending, net revenues for the prior fiscal year currently estimated to have resulted from enactment of health care reform. If the "net increase in Federal health care spending" exceeds "net revenues," the difference shall be designated the deficit increase for the prior fiscal year resulting from health care reform legislation.

**Example of calculation:** In January of 1997, CBO and OMB will determine how much total Federal health care spending was in fiscal year 1996; they will subtract from that total, the amount of pre-health care reform spending which had been projected by OMB for FY 1996 (in the pre-health care reform baseline) as adjusted to exclude increases in spending unrelated to health care; the resulting number will reflect the net increase in Federal health care spending for FY 96 which has resulted from health care reform; finally, the net revenues projected to have been raised in FY 96 due to health care reform are offset against the net spending increase; this yields the FY 96 deficit increase, if any, resulting from health care reform.

##### **5. Determination of Required Deficit Reduction**

If OMB has determined that health care reform caused an increase in the deficit in the prior fiscal year, OMB must report in the President's Budget how much deficit reduction is required to be implemented in the upcoming fiscal year. This is to be determined by inflating the amount of deficit increase from the prior fiscal year, using the CPI-U.

For example, suppose that OMB determines in January 1997 that in Fiscal Year 1996, the deficit increased by \$10 billion due to health care reform. OMB would then apply the projected inflation rate for FY 97 and FY 98 to the \$10 billion deficit increase to determine how much of a deficit offset is required in FY 98. If inflation is estimated to be 3.1 percent in fiscal years 1997 and 1998, the adjusted deficit reduction required for FY 98 would be \$10.63 billion.

These determinations would occur every two years, beginning in 1997 and through 2005. This biennial structure would operate to avoid double-counting deficit increases. For example, suppose a determination in 1997 causes an automatic subsidy reduction in FY 98. If there was a deficit determination only one year later in 1998, the "look-back" at FY 97 would fail to capture the effects of the already implemented deficit reduction. However, the biennial process, which calls for a look back in 1999 at FY 98, will take into account the implemented deficit reduction under the prior cycle.

#### **6. Determination of Required Reductions**

If OMB reports in the President's budget that deficit reduction is required for the upcoming fiscal year to offset a deficit increase resulting from health care reform, the President is required on September 20 to implement proportional reductions in: (1) subsidies and (2) the tax credit for insurance premiums paid by the self-employed and individuals not covered at work--unless alternative deficit reduction legislation is enacted in the interim. The President must report in the Budget for that fiscal year specifically what reductions are to be implemented on September 20.

The required deficit reduction is to be achieved through a progressive formula, so that: (1) subsidies for the lower income recipients would receive the smallest reductions and subsidies for the higher income recipients would receive the largest reductions; and (2) the reduction in the tax credit for insurance premiums paid by the self-employed and individuals not covered at work would be applied progressively, based on income.

#### **7. Alternative Deficit Reduction Legislation**

A procedure is established for fast-track consideration of a legislative alternative to the automatic reductions. If OMB determines a deficit increase attributable to health care reform for the prior fiscal year, the President would be required to submit to Congress by June 1: (1) alternative deficit reduction legislation designed to achieve the required deficit reduction for the upcoming fiscal year; or (2) a report explaining why such alternative legislation is not being transmitted.

It is expected that the alternative deficit reduction legislation would be developed through a process similar to the trade fast-track

process used for the implementing bills for the North American Free Trade Agreement and the Uruguay Round of the General Agreement on Tariffs and Trade. Those processes have involved extensive consultation among the Senate and House committees of jurisdiction through "mock mark-ups and conferences," as well as extensive consultation with the Executive Branch.

The alternative deficit reduction legislation is to be submitted as a joint resolution stating in the resolving clause that the "Congress has determined that it is necessary to avert automatic reductions in Federal health care subsidies by enacting the following changes in law, which are estimated to eliminate projected deficit increases resulting from the enactment of health care reform."

If alternative deficit reduction legislation is transmitted to the Congress, CBO is to report to the Senate and House of Representatives by June 10, estimates of whether the alternative deficit reduction language submitted by the President will produce the same amount of deficit reduction in the upcoming fiscal year as is required to be achieved through automatic reductions (as estimated by OMB). If the Chairmen of the Senate and House Budget Committees certify by June 13, that the alternative deficit reduction legislation produces the required amount of deficit reduction, it will proceed through the Congress under the following procedural "fast-track" protections.

#### **8. Fast-Track Procedures**

**Introduction of Resolution.**--Under the fast-track procedure, the Majority Leaders of the House of Representatives and the Senate are required, no later than June 15, to introduce the alternative deficit reduction legislation, transmitted by the President, on behalf of themselves and the respective Minority Leaders.

**Referral.**--The legislation is to be referred to all relevant committees. Committees are to review the legislation, but no committee amendments are permitted.

**Discharge.**--On June 25, House committees are to be discharged of alternative deficit reduction legislation if they have not yet reported.

**Vote by House of Representatives.**--The House of Representatives must vote on the alternative deficit reduction legislation no later than July 10. During consideration by the House of Representatives, the bill may not be amended and debate is limited to 20 hours.

**Discharge by Senate Committees.**--If alternative deficit reduction legislation passes the House of Representatives, all Senate committees to which the legislation was referred are discharged no later than July 20 if they have not reported the legislation.

**Vote by Senate.**--The Senate must vote on the alternative deficit reduction legislation no later than August 5. During consideration by the

Senate, the bill may not be amended and debate on the bill (and all motions and appeals) is limited to 20 hours, equally divided between the Majority and Minority Leaders or their designees. A motion to proceed to the alternative deficit reduction legislation is non-debatable. Motions to recommit the alternative deficit reduction legislation are not in order. Section 313 of the Congressional Budget and Impoundment Control Act of 1974, commonly known as the "Byrd Rule," would apply in the Senate so that any "non-budgetary" provisions included in the alternative deficit reduction legislation, as submitted by the President, could be stricken from the bill.

#### **9. Implementation of Deficit Reduction**

If alternative deficit reduction legislation has not been enacted by September 20: (1) the President is required to implement automatic reductions in subsidies by executive order; and (2) the Secretary of the Treasury is required to promulgate regulations reducing the tax credit for insurance premiums paid by the self-employed and individuals not covered at work.

#### **10. No-growth suspension**

No later than July 1, the Chairman of the Council of Economic Advisers (CEA) shall make a "no-growth" report to the President and the Congress, if the Commerce Department has reported less than zero percent real economic growth for the fourth quarter of the preceding calendar year and the first quarter of the current calendar year. If the CEA Chairman makes a no-growth report to the President and the Congress: (1) the President shall not issue an executive order implementing across-the-board reductions in subsidies and the Secretary of the Treasury shall not issue Treasury regulations reducing tax credits; and (2) the fast-track procedures in the Congress shall be automatically suspended. If an alternative deficit reduction resolution is in the fast-track process when a no-growth report is issued, legislative consideration may continue, but without the expedited procedures of the fast-track.

#### **11. GAO Audit of Reductions**

If alternative deficit reduction legislation has been enacted, or if the President has issued an executive order and the Secretary of the Treasury has issued regulations imposing the required reductions, the General Accounting Office is required to report to Congress no later than November 1: (1) in the case of an executive order and Treasury regulations, an analysis of whether the reductions have been implemented according to statutory requirements; or (2) if alternative deficit reduction legislation has been enacted, an analysis of whether the reductions have been implemented as required in the statute.