

*Dole*  
ALTERNATIVE HEALTH REFORM PROPOSAL

**I. GUARANTEED ACCESS TO COVERAGE**

**A. Insurance Reforms**

1. There will be two market sectors:
  - a. Individuals and small employers size 2 to 50.
  - b. Large groups (employers, associations and MEWAs with more than 50 employees or members).
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 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. 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 (4) below.
  - g. Health plans may impose group participation requirements as long as they are standard for all groups.
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 within 3 months of 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 within 6 months of 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 (for under age 65) 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 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] benefit 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).
  - 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.
- 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.

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 group market only.) States are to risk adjust across insured health plans and self-insured plans of employers with 50 or fewer employees. All employers with 50 or fewer employees 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. 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, MEWAs and Association Plans**

1. Nothing in this Act requires the establishment of a purchasing group -- nor prohibits the establishment of more than one --in an area. Membership in purchasing cooperatives shall be voluntary.
2. Purchasing groups established to serve the individual and small group markets must be open to all individuals and small employers who wish to join.
3. Purchasing groups shall be permitted to contract selectively with qualified health plans. If a purchasing cooperative negotiates a premium rate lower than the health plan's community rate, that rate becomes the plan's new community rate.
4. Any health plan offering a benefit package through a purchasing cooperative must offer at least the [FedMed] benefit package through the cooperative.
5. Insurers are prohibited from establishing a purchasing cooperative but may administer one under contract with the purchasing cooperative.

6. 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.

7. 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) 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 50 lives.
  - ii. Complete a certification procedure established by the Secretary of Labor.
  - iii. Meet all the requirements in 7.a. and if self-insured, meet the additional requirements in 7.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. No deduction shall be allowed to any employer or individual who purchases health insurance from or through an association health plan unless the association provides written notice to each contributing employer and individual that the association and the health plan have met the applicable requirements of this section.
  - g. Taft-Hartley health plans, rural electric and telephone cooperative health plans and church association health plans are exempt from all requirements described in this section.

**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.
- 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 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 and for premiums and medical expenses for long-term care. Premiums for catastrophic coverage cannot be paid out of MSA.
- 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 currently 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. Subsidies would be provided for premiums only, up to a maximum amount.
- f. By regulations, the Secretary shall establish a [FedMed] benefits package that includes, at a minimum, the categories of benefits described in law Title V of the United States Code for the Federal Employees Health Benefit program and in the HMO Act of 1973. 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.
- g. Coverage decisions about new procedures and technologies are made by health plans, using criteria for medical appropriateness developed by the Secretary.
- h. 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 fee-for-service version, cost sharing shall be similar to the health plan in the Federal Employees Health Benefit program with the highest enrollment, adjusted for the special needs and financial capabilities of the population eligible for subsidies.
  - ii. For a managed care 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.

- i. 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.
- j. 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.
- k. 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).
- l. Individuals and families with income below 90% of the Federal poverty level (100% in future years, if funding is available) would receive a full premium subsidy.
- m. 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. In addition, no subsidy would be payable for those entitled to a subsidy of \$150 or less.
- n. 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.
- o. Eligibility for subsidies will be calculated on an annual basis. Income tax return information will be used in determining eligibility to the extent possible.
- p. 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.

- q. 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.
- r. 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.
- s. 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.
- t. 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.
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 (ramped up). 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;

- v. Health plans may select a state-approved or HHS-approved certifying organization to complete their certifications; and,
  - vi. 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 red-lining 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

All state anti-managed care laws will be preempted, such as (but not limited to):

- a. Anti-managed care (such as "any willing provider"),
- b. Corporate practice of medicine,
- c. Insurance benefit mandates,
- d. Cost-sharing mandates, and
- e. Utilization review mandates.

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. 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.
- 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.
- i. 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

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.

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 effectively 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. Special privileges for areas designated as underserved include:

- a. Secretary, in health plan standards, may require health plans in adjoining areas to include the underserved area in their service area;
- b. State may apply certain special risk adjustment (extra payments) to increase the compensation of health plans serving the underserved area;
- c. Federal assistance for network development (planning and capital dollars) and to increase primary care services will be given first to areas designated as underserved; and
- d. Technical assistance will be available to these areas to meet the quality, consumer information, administrative simplification, access, health plan certification, and other requirements of reforms (from the Secretary of HHS and the Quality Assurance and Consumer Information Agency.)

3. Investment in Infrastructure

a. Network Development Funds-

i. Planning funds-

- a. Grants for use in planning and development of networks of providers and plans;
- b. Other planning grants to transition facilities to compete more effectively (these grants replace the rural transition grant program);

- ii. 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
  - b. 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. Tax credits, expensing of medical equipment, and loan repayments for primary care practitioners in geographic areas recognized by the Federal Office of Shortage Designation and any new underserved areas as defined in #2 above.
  - b. 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 Prenatal Care services and outreach grants for programs serving women at risk of low birthweight babies;
    - ii. School-based Health Education -- Increase assistance to local education agencies for pre-school programs that provide comprehensive health education to children; and
    - iii. Other Primary and Preventive Services -- Increase authorization of targeted programs such as: childhood immunization, maternal and child health, breast and cervical cancer prevention, HIV early intervention, tuberculosis prevention, health care for the homeless, and community and migrant health centers.
  - c. 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 1999; and
    - iii. Fully fund the National Health Service Corps;
  - d. Funding for telemedicine and related telecommunications technology support for frontier and rural areas; and
  - e. Frontier and rural areas medical transportation funding.

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;
- e. Increase Medicare reimbursement to physician assistants and nurse practitioners in rural and urban areas; and
- f. Medicare and Medicaid waivers to establish rural networks.

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.

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) The role of the Commission will be set in law 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) Process for funding (consider consortia and the current "residency match" program as mechanisms to distribute dollars);
- (c) Future payment policy for Medicare for graduate medical education - such recommendations shall explicitly address possible all-payer pool, its design and function;
- (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. The consortia concept will be further developed for demonstrations.

b. Funding:

- i. A broader base (complementing the Medicare dollars) will be explored by the commission to fund graduate medical education, research, and teaching hospitals.
- ii. Medicare. During a transition period, DME and IME dollars will continue. Modifications will be made to the two funds as follows:
  - (1) DME -- Formula will be modified to be more equitable and better reflect current situations and eliminate radical variances in per resident average amounts. Ambulatory, rural, and other non-hospital sites will be encouraged and reimbursed.
  - (2) IME -- Will continue as a separate pool, but the fund will be reorganized after the commission's explorations. The specific issues of the service versus training roles in public hospitals will be considered along with phase out plans for the Medicare and Medicaid DSH funds. IME funds will also be available for non-hospital sites, if appropriate.
  - (3) 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 and IME 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 in Medicare DME and IME formula changes.

- 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 should be deducted from award to plaintiff.
- e. Limits on Attorneys Fees - a sliding scale limit, to be determined later (California is too generous).
- 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 six years after discovery or before minor turns 11, whichever is later.
- g. Clear and Convincing Standard for first seen obstetric cases.
- h. Drugs and Devices. No punitives if approved by FDA and no fraud in the approval.
- i. Punitive Damages Reform. Includes requirement of proof dedication of funds, definition of liability standards, including vicarious liability.
- j. Right of Subrogation or Automatic Subrogation under Collateral Source Rule.
- k. Consumer Protections - Require Risk Management at hospitals; extend good faith liability protection to state licensure boards; some liability protection for those providers reporting other providers to state licensure boards; permit licensure boards to enter agreements with professional societies to license and review health care practitioners (Michel bill).

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
    - 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. Tax credits will be provided for the cost of personal assistance services for the working disabled.
  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. At the option of the state, Medicaid recipients would be permitted to enroll in any certified health plan offered in the geographic area. The state may not restrict the individual's choice of plan. The state would not be required to pay more than the maximum subsidy amount for the subsidized population in the geographic area.
- b. The number of individuals electing to enroll in a certified health plan will be limited to 15% of the eligible Medicaid population in the state in each of the first 3 years, increasing by 10 percentage points (e.g., 25, 35, 45, etc.) in each year thereafter.
- c. The Secretary shall study the impact on qualified health plan premiums and make recommendations to the Congress.
- d. The Act 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. Medicaid recipients would be permitted to enroll in one of at least 2 qualified risk contract plans offered in the area. The state may not restrict the individual's choice of plan.
- e. Federal Medicaid spending for acute care services, including expenditures for payments to qualified health plans, will be subject to an annual payment cap for each state. The cap will be determined by multiplying the per-capita amount times the number of Medicaid recipients in the state. The per-capita amount for FY 1996 is equal to 118% of the per-capita amount for FY 1994. The per-capita amount for FY 1994 will include all Federal expenditures for acute care services excluding DSH payments.
- f. In years after 1996, the per-capita amount is equal to the per-capita amount for the previous fiscal year increased by 6 percent for fiscal years 1997 through 2000, and 5 percent for fiscal years 2001 and beyond.
- g. States could not eliminate coverage of eligibility groups covered by the state as of 1994.
- h. 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 and Hawaii.
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 become certified providers 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. Maintain Medicare as 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,
    - ii. Remaining in employer sponsored plans, and
    - iii. 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 of HHS is to define a standard benefit package that includes the same items and services covered under Medicare but with cost-sharing appropriate for managed care plans, such as health maintenance organizations or preferred provider organizations.
  - b. The Secretary is to also define standard supplements to be offered with risk contracts:
    - i. Catastrophic coverage (out-of-pocket limit)
    - ii. Prescription drug coverage
    - iii. Preventive services coverage
  - c. The Secretary shall provide Medicare beneficiaries information on medicare options available in a beneficiary's area. Information shall be

- presented annually in an easy to understand comparable format.
- d. Improved Medicare risk contract payment methodology:
    - i. In determining the amount of payment for Medicare risk contracts, the Secretary shall use a direct calculation methodology applied to each market area, adjusted to reflect use of military, veterans, and other federal health program services.
    - ii. The Secretary shall establish Medicare market areas to replace the current county based system. Metropolitan statistical areas can't be divided into different market areas.
  - e. The Secretary shall conduct an annual open enrollment period. Medicare beneficiaries who enroll in risk contract plans can only disenroll during an open enrollment period, except:
    - i. If their primary care physician leaves the health plan; and
    - ii. If they succeed in obtaining permission to disenroll through an appeals process where they have successfully demonstrated cause.
4. Medicare Select will be a permanent Medigap option in all states.

**C. Indian Health Service**

- 1. The Indian Health Service should remain as a separate program consistent with the Indian Self-Determination Act and the Indian Health Care Improvement Act.
- 2. Eligibility rules should be consistent with the Indian Health Care Improvement Act Amendments in order to ensure Native Americans are not left uncovered.

**D. Veterans Administration/Defense**

- 1. VA would continue as separate, independent health care system for veterans. VA and DoD would be encouraged to expand current programs for sharing medical resources.
- 2. Service-connected, low-income, and other core (ex-POWs, World War I; etc.) veterans would keep their current priority for care.

#### IV. FINANCING

##### A. Spending Savings

1. Postal Service Retirement  
Require the U.S.P.S. to fund the U.S.P.S. Retirement System in the U.S.P.S. budget rather than the Federal Budget. This would free funds from the Federal budget.
2. 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.** 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 Act 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.** OBRA 93 eliminated the inflation adjustment to the home health limits for two years. This Act allows a partial catch-up for home health after the freeze expires on July 1, 1996.
- g. **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.
- h. **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.
- i. **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%.
- j. **Establish outpatient prospective payment system for hospital outpatient departments.** The Secretary of HHS is directed to establish a prospective payment system for hospital outpatient department services by January, 1995. If such a system is not established by that time, the Secretary would reduce hospital outpatient department payments sufficiently to achieve the anticipated savings.
- k. **Extend OBRA 93 Medicare Secondary Payor Data Match with SSA and IRS.** OBRA 93 included an extension of the data match between HCFA, IRS and SSA to identify the primary payers for Medicare enrollees with health coverage in addition to Medicare.
- l. **Extend OBRA '93 disabled provisions.** Extends the OBRA '93 provision making Medicare the secondary payor for disabled Medicare beneficiaries who have employer sponsored coverage.
- m. **Extend the End-stage renal disease secondary payor provision.** Makes Medicare the secondary payer for ESRD patients with employer sponsored health insurance for 24 months, instead of the current 18 months.

3. Medicaid Savings

- a. Federal Medicaid expenditures will be capped on a per-capita basis at a specified rate of growth (6 percent for years 1997-2000, and 5 percent per year for years 2001 and later).
- b. Medicaid payments for disproportionate share hospitals (DSH) would be reduced by 25 percent (starting in 1996) to help pay for subsidies for low-income individuals and families without health insurance.

B. Budget "Fail-Safe" Mechanism

1. To ensure that new spending for health insurance subsidies for low-income persons and the health insurance tax deductions (including MSAs) do not exceed projections and increase the federal budget deficit, a fail-safe mechanism is included.
2. A baseline consisting of current projected spending for Medicare and Medicaid expenditures is established in the bill.
3. In any year that the Director of the Office of Management and Budget (OMB) notifies Congress that total federal spending for:
  - a. Medicare,
  - b. Medicaid,
  - c. Low-income health insurance subsidies, and
  - d. New tax spending for health insurance deductions (including MSAs)will exceed the statutory baseline, the following will occur:
  - a. The phase-in of the tax deductions will be frozen at whatever percentage it is;
  - b. Contributions to MSAs will be frozen; and,
  - c. The low-income subsidy phase-in will be slowed or rolled back to the extent necessary to assure no deficit spending.
4. Congress may enact alternative savings measures to avoid the automatic reduction in subsidies.

## COMPARISON

### ALTERNATIVE

- Guaranteed Access to Coverage
- Unlimited Choice of Benefit Packages
- Improved Private Health Care System
- No Mandates or Price Controls
- No Taxes -- Financed Only With Spending Cuts
- Protection Against Deficit Increases
- Allows Self-Insured Health Plans to Continue at Any Firm Size

### KENNEDY/CLINTON

- Mandated Universal Coverage
- 1 Standard Benefit Package
- Widespread Government Regulation of Health Care
- Anti-Job Mandates & Anti-Competitive Price Controls
- To Be Financed With Mandates, New Payroll Tax, Other Tax Increases & Spending Cuts
- Increases the Deficit
- Bans Self-Insured Health Plans of Firms under 500 Employees

## SUMMARY OF DRAFT ALTERNATIVE

- I. Guaranteed Access to Coverage
- II. Improved Private Health Care System
- III. Improvements to Existing Federal Health Programs
- IV. Financed by Spending Cuts with Protection Against Deficit Spending

## I. Guaranteed Access to Coverage

- Unlimited Choice of Benefit Packages
- Insurance Reforms
  - Guaranteed Issue and Renewal
  - Eliminate Pre-Existing Condition Exclusions for Those With Continuous Coverage (Portability)
  - Modified Community Rating for Individuals and Small Groups
- No Ban on Self-Insurance or Association Plans (MEWAs)
- Voluntary Purchasing Cooperatives
- Small Employer Access to Federal Employee Plans (FEHBP)
- Insurance Tax Deduction for Americans Without Employer-Provided Coverage
- Medical Savings Accounts (with Catastrophic Insurance)
- Safety-Net Program to Subsidize Private Insurance for Low-Income Americans (Up to 150% of Fed. Poverty--e.g., up to \$22,200 for Family of 4)

## II. Improved Private Health Care System

- Medical Malpractice Reform
  - Consumer Value Program for Quality Health Care
    - State-Implemented Guidelines for Health Plans
    - Consumer Report Cards
    - Preempts State Anti-Managed Care Laws
  - Paperwork Simplification
  - Improved Health Care for Underserved Rural and Urban Areas  
(Includes Funding for Community Health Centers and Other Primary Care Services)
  - Improvements to Medical Education
- [● Antitrust Reform--Open]

### III. Improvements to Existing Federal Health Care Programs

- Phase Medicaid Into Private Insurance
  - Improve Medicare Managed Care Option
  - Maintain as Separate Programs:
    - Indian Health Service
    - Veterans Administration Health Programs
    - Department of Defense Health Programs
-

#### IV. Financed by Spending Cuts Only

- Mainstream Medicaid [ \$ 40 billion/5 years ]
- Medicare Reforms [ \$ 60 billion/5 years ]
- Postal Retirement Reform [ \$ 13 billion/5 years ]
- Budget Fail-Safe to Protect Against Deficit Spending

8/11/94

## The Bob Dole "You're Out Of Luck" Plan

### **If you're looking for health insurance you can count on....you're out of luck.**

Unlike Senator Mitchell's plan, which guarantees secure, affordable insurance, the Dole plan provides no guarantee of decent coverage. Millions would still have phony, fly-by-night insurance, and an estimated 30 million Americans would have no coverage at all. [Lewin-VHI, July 1994]

### **If you're looking for health insurance you can afford....you're out of luck.**

The Dole plan allows insurance companies to continue to raise rates higher and higher each year, and to charge older people three to four times more than younger people. Some small businesses will continue to pay more than others, and some families more than other families. You could still work hard, pay your premiums, and have medical bills sent back "not covered".

As his Republican Colleague John Danforth said of the Dole plan, *"It creates a new entitlement and it doesn't have any cost control....I don't think we can do that."* [AP, 8/10/94]

Newsweek predicts the Dole plan *"will increase premiums for middle class people and could increase [the] number of uninsured."* [Newsweek, July 25, p. 19]

### **If you're a senior.....you're out of luck.**

The Dole bill takes significant money out of Medicare and does little or nothing for seniors - no prescription drug coverage, and pitiful help with long-term care.

### **If you're a child with no insurance....you're out of luck**

The Dole plan will continue to leave an estimated 30 million people with no coverage, including 6.2 million children. What does that mean? It means millions of kids will go without seeing the doctor, millions will not get needed health care in time to prevent disabling illnesses. And under Dole's plan, even workers who get coverage can find that their insurance policy covers them, but not their kids. Employers will continue to drop back family coverage and offer bare-bones, worker-only policies -- leaving millions more children at risk of losing the coverage they have now.

### **If you're a small business....you're out of luck**

The Dole bill continues to permit insurers to charge higher rates to small employers just because they're small. [Dole Bill Sec.9002(d)(1) p. 117] Small companies pay 35% more on average as it is, and this insurance company abuse against smaller employers will mean the little guy still gets overcharged. And unlike the Mitchell proposal, there are no subsidies to help small businesses who can't afford coverage today afford it tomorrow:

### **If you lose your job....you're out of luck**

The Dole plan theoretically allows people to take their same insurance with them when they leave their job and go to a new one (portability), this only helps those who can pay the full premium themselves. That is not realistic for most people, since they can't afford the full cost of coverage, especially if they are without a job. In fact, most workers have that protection now, either through state insurance laws or through COBRA coverage. But as a recent study by the Department of Labor shows, only one in five can take advantage of it -- the rest can't afford it. Even Senator Chafee admits: *"I have great trouble seeing how you get portability without universal coverage."*

## **The Bob Dole "The Insurance Company Protection" Plan**

### **Insurance Companies Can Still Deny Coverage Through Loopholes and Fine Print**

While the Dole plan describes a standard benefits package (called the FedMed package) and says that every health plan has to offer that option, it also allows insurance companies to offer any benefits package they want. [Dole Bill Sec. 21115 (a) p.85 ] This allows insurance companies to effectively deny coverage of certain illnesses by structuring benefits packages to not cover certain treatments. Millions of Americans will continue to face the nightmare of insurance claims coming back: "Sorry, not covered."

### **Few People Will Benefit From the Community Rating Reforms**

Many of the insurance reforms in the Dole bill, modified community rating for example, apply only to the "community rated market" -- but there is no "community" in the bill's reform. Any employer can self-insure, so employers with young, healthy employees will likely stay out of the community-rated pool and provide insurance on their own. In addition, associations can opt out of the community-rated pool and buy as a group, leaving even fewer people in the pool. This "vicious spiral" will lead to very high premiums in the community-rated market and will encourage healthier people to drop coverage.

### **Mid-Size Businesses Could Face Large Premium Increases**

Under the Dole Bill, many small to medium-sized companies would be left between a rock and a hard place -- too small to self-insure, but too large to get the benefits of insurance reform in the community-rated pool. An employer with 55 employees could have extremely high costs because of just one employee with a history of illness. They could see their rates jacked up based on one worker with a serious medical condition. For most firms in this category, insurance costs will continue to be high and unpredictable.

### **Insurance Companies Can Decide They Don't Want to Sell to Small Businesses**

Insurance companies can decide that they want to avoid the small business sector altogether and refuse to sell insurance to any small businesses. Under the Dole plan, they could continue to deny coverage to small businesses.

### **Insurance Company Profits Protected, Middle Class Families Left Waiting**

The Dole plan limits, but does not eliminate, the ability of insurance companies to deny or forestall coverage for "pre-existing conditions" [for six months to a year]. While all agree that pre-existing condition limitations are a necessary transition tool to universal coverage, the Dole bill will never get there, so exclusions will never go away.

### **Insurance Companies Could Charge You Three to Four Times More Because You're Older**

The Dole plan allows insurance companies to charge older workers three to four times more for insurance than younger workers, and twice as much as under Senator Mitchell's bill.

### **Americans with Insurance Would Still Be At Risk of Losing It**

The real bottomline is that under the Dole plan, everyone remains at risk of losing the insurance they have now -- because under a non-universal system, no one is guaranteed protection. As Newsweek magazine reported last week, the Dole plan "will increase premiums for middle class people and could increase [the] number of uninsured." [Newsweek, July 25, p. 19]

## **The Bob Dole "Cheating Seniors" Plan**

### **Raids Medicare and Gives Seniors Nothing Back**

While other bills reduce the rate of growth in Medicare, the Dole Bill relies heavily on savings from the Medicare program to finance reform. The Dole bill gives nothing back to the older Americans that Medicare was set up to serve. No help with prescription drugs. Nothing but lip service on long-term care.

### **Forces Millions of Seniors to Choose Between Food and Medicine**

The Dole plan does not add prescription drug coverage to Medicare -- giving millions of older Americans no help paying for costly prescriptions. Prescription drug costs are the highest out-of-pocket expense for three out of four seniors, and the Dole plan would provide no help, forcing millions of older Americans to continue to choose between food and medicine. More than 31 million Americans under age 65, and 18.5 million Americans over age 65 would be denied prescription drug coverage under the Dole bill. [NCSC, "Six Reasons the Dole Bill is Bad for Seniors," 7/94] That's just one reason the AARP calls the Dole bill *"a harmful prescription for older Americans"*

### **Leaves Older Americans in Need of Long-Term Care at Grave Risk**

Unlike Senator Mitchell's proposal, which invests \$50 billion in a new home and community-based long-term care program, the Dole bill does next to nothing for long-term care. Older Americans in need of assistance will continue to face no choice but to enter nursing homes.

### **Discriminates Against Small Companies With Older Workers**

Small firms with more than 50 employees will remain at the mercy of insurance companies who charge higher rates for older workers, higher rates for sicker workers, and raise rates when even one employee gets sick. This means older workers will have their jobs at risk when their employers look at their insurance premiums.

### **Insurance Companies Could Charge Older Americans Three to Four Times More Than Those Younger, and Double What They'd Be Charged Under the Mitchell Plan**

The Dole plan allows insurance companies to charge older workers three to four times more for insurance than younger workers, and twice as much as under Senator Mitchell's bill.

# Senate Republican Health Care Task Force Consensus Principles for Health Care Reform

8/6/93

## SIGNATORIES

Robert F. Bennett (UT)	Judd Gregg (NH)
Christopher S. Bond (MO)	Orrin G. Hatch (UT)
Conrad Burns (MT)	Mark Hatfield (OR)
John H. Chafee (RI)	Nancy Landon Kassebaum (KS)
Bill Cohen (ME)	Dirk Kempthorne (ID)
John C. Danforth (MO)	Richard Lugar (IN)
Bob Dole (KS)	Frank Murkowski (AK)
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Dave Durenberger (MN)	Alan Simpson (WY)
Lauch Faircloth (NC)	Arlen Specter (PA)
Slade Gorton (WA)	Ted Stevens (AK)
Charles E. Grassley (IA)	John W. Warner (VA)

## Statement of Principles

We believe that the following three goals are fundamental to a successful health care reform effort:

1. Quality of care must be maintained;
2. Every citizen must be covered;
3. The growth of health care costs must be restrained.

As members of the Senate Republican Health Care Task Force, we have been working to devise a proposal for comprehensive reform to achieve these goals. Health care reform will not and should not be forced on the American people by one political party. If we are to restructure a large part of our economy, we must do so together, Republicans and Democrats, with the participation of consumers, providers, and the American people.

The United States offers the finest health care in the world. For the eighty-five percent of Americans who are currently insured, our system offers the world's highest quality and most technologically-advanced care. For the seriously ill, our skilled providers and state-of-the-art

treatments offer greater hope than any other system in the world. And those employed by large companies are often able to choose from a variety of health insurance options with reasonable premiums.

The health care industry represents one-seventh, or fifteen percent, of our economy. Hospitals, physicians' offices, visiting nurses, nursing homes, medical schools, equipment manufacturers, research institutions and many other health care-related endeavors employ some 12 million people -- over twice the number employed by the defense industry.

On the other hand, families, businesses, and governments are struggling to keep pace with ever-increasing health-related costs. Currently, Americans spend more for health care than any country in the world. Our federal deficit grows larger and larger, driven to a considerable extent by spiraling health costs.

Yet, despite this spending, even those with insurance fear that their coverage, or that of their loved ones, is not secure. For those not employed by a large company, the cost of insurance is often out of reach. And, for the fifteen percent of Americans without insurance, getting treatment for an illness is an uncertain proposition, while preventive care is frequently unavailable and often underutilized.

Our challenge is to solve these problems, provide coverage for everyone and preserve the elements of our system that all Americans value. The following are the concepts upon which our reform proposal will be based.

### **Right of Choice and Flexibility**

The primary goal of reform should be to give all Americans an equal opportunity to influence the cost and quality of the health care they receive. The centerpiece of any plan must not be government micro-management. Instead, we believe the rules by which insurers, purchasers and providers operate must be changed in order to put all three on equal footing.

Large businesses today can constrain their health care costs by exercising their marketplace purchasing power. Thus, their employees often have the benefit of generous family insurance coverage with low cost-sharing requirements.

By helping them to join together, we can give small businesses and

individuals the same opportunity. We believe a system of private-sector purchasing cooperatives for small businesses and individuals could provide the solution. These cooperatives should not be government-run bureaucracies, but rather, non-regulatory facilitators -- owned and operated by the members they serve.

Insurance plans would be offered through the purchasing cooperatives to individuals and the employees of small businesses. All plans would be required to meet certain standards to protect consumers.

The current practice of "cherry picking" (attracting the healthiest people with low premiums, while refusing to cover those who are sick) is wrong. Today we have a system where one is only a heart attack away from losing his or her health insurance. We believe insurers should be prohibited from canceling any policy or raising the cost of premiums when someone becomes ill.

We also favor changes to ensure that anyone who moves from one area to another, or changes jobs, can continue to get insurance coverage.

In addition, defined comparable benefit packages should be established, and required to be offered by all plans, to prevent another way of gaming the insurance system -- offering a package of benefits that is attractive only so long as a person is healthy.

We believe that, in combination, these changes would foster an environment in which consumers could exercise choice among plans that are challenged to excel in quality of care and service at an attractive price. We also believe that Medicare beneficiaries should be given real opportunities to choose a health plan with better benefits -- such as drug coverage -- which is also more cost-effective. Likewise, Medicaid beneficiaries, who now have a difficult time finding care, should be able to choose an alternative plan.

### Containing Costs

This new environment will give consumers much greater power to ensure that health care providers and insurers provide high quality care and make efficient use of our health care resources. We believe a significant decrease in the rate of growth for health care spending will be achieved in both private and public programs.

In addition, we firmly believe that reform of our medical liability laws is essential to bringing the cost of our system under control. Excessive medical tests and procedures performed defensively by doctors, continue to drive up health care costs.

We believe another area that offers tremendous hope for improving quality and reducing costs is building a computerized health care information infrastructure. The costs of manual processing and paper shuffling inherent in our insurance claims system today adds \$135 billion a year to the cost of care -- in addition to bedeviling consumers with complex forms.

With uniform standards and strong statutory protection to ensure privacy and confidentiality, every American could have a personal health card -- like an ATM bank card -- to provide vital health information electronically to their doctor. For travelers such a system might mean the difference between life and death. A computerized system like this would help with outcomes research, and would eliminate fraud and unnecessary health procedures.

Finally, we believe consumers must all be given an equal financial stake in the cost of care. One way to achieve this goal is to reform the tax code.

Our tax system has inequities which permit corporations to deduct the full cost of providing expensive gold-plated health coverage to their employees. On the other hand, farmers, ranchers, truck-drivers and other self-employed persons can deduct only 25% of their health insurance premium.

Furthermore, employees of large corporations receive their health benefits tax-free, while those who purchase their own insurance with no employer assistance, pay for such coverage with after-tax dollars. Consequently, a large proportion of the tax benefits for purchasing health insurance go to those with gold-plated insurance plans.

We believe everyone should be treated equally. All Americans should be eligible for the same health care tax deductions. One option might be to change the tax system so that the amount individuals or corporations can deduct would be limited. Under such an option, premium costs above the limit would not be deductible by the employer and would be taxable income to the employee. The savings derived from this change could be used to allow others to deduct 100% of their health insurance premiums up to this limit.

We believe that, within this reformed and functioning system consumers would have choice, as well as the motive to be cost-conscious. Americans would keep their right to choose the insurance plan that best fits their needs -- from staff model HMOs to a traditional fee-for-service system with no restrictions. But, those who choose the higher cost plans will no longer be subsidized fully by those less fortunate.

### Universal Coverage

We believe that all Americans should have access to a broad range of affordable insurance plans, and that the principles outlined herein will expand access greatly. The ability to deduct the cost of coverage, combined with more affordable premiums, will allow many who are uninsured today to purchase coverage with no additional federal assistance. For those who still cannot afford coverage, we believe federal financial assistance should be made available. Our proposal will provide such assistance.

### Financing

During our examination of this issue, we have found that health care cost estimates and projections vary considerably. We believe any reform plan should reflect this fact, and take into account that no one can be certain of how reform will affect health spending.

Thus, we believe there should be a two-pronged approach to financing the coverage of the uninsured. First, reductions in federal spending should be made and those savings should be used immediately to finance coverage for those most in need. Second, we believe that the structural changes outlined earlier will yield additional savings in government health spending. Actual (rather than projected) savings should be assessed and a schedule of further expansions over the following years should be outlined in statute. If actual savings were greater or lesser than needed to pay for the scheduled expansion, the schedule would be sped-up or delayed until the two were in balance.

In attempting to solve health care problems we must be mindful of the first principle of medicine--"Do no harm." Any financing mechanism should, for example, avoid taxes on payrolls, which would discourage employment and cost jobs, jeopardizing coverage for even more Americans.

Too often, government tries to do too much, too quickly at too great

a cost to taxpayers. As our reforms cut health costs and produce savings, we can afford to phase in new coverage. This approach would squeeze health costs and cut wasteful spending first. Providing coverage up front while promising to cut costs later is irresponsible.

### **Individual Responsibility**

Once the system has been improved so that everyone has access to affordable health insurance and federal assistance has been fully phased in, we believe individuals must assume responsibility for securing their own insurance. As long as there are adequate subsidies to make health insurance affordable for the poor and the unemployed, everyone must take responsibility for preparing for an unexpected health crisis.

Recently, the Senate took a bipartisan step to encourage individual responsibility by passing an amendment by Senator Bumpers to permit states to withhold welfare payments when parents have failed to get their child immunized. This is the type of individual responsibility that must be present in our reformed health care system.

### **Rural, Frontier, and Urban Areas**

There are significant parts of the United States which have limited health care services available. We believe communities in rural, frontier (especially Alaska) and urban America face unique health care delivery and access challenges. Any reform plan must recognize that these areas may be the last to enjoy the benefits of change, and therefore must directly address their special needs in the short term.

### **State Flexibility**

We believe any reform proposal must give states maximum flexibility to enact their own health care reforms. Citizens of a state should be allowed to join together to develop innovative new ways to deliver health care without being hampered by an inflexible federal system.

### **What Won't Work**

We are greatly concerned by talk among some health reformers of government regulations and mandates. Like so many federal "solutions" they may appear neat and simple on paper, but will lead to disaster when implemented. Chief among these magical cures are arbitrary government-micromanaged global budgets, and bureaucratic price controls. Price controls do not work and encourage efforts to "game the

system."

A cursory look at the past ten years of statutory and regulatory changes in Medicare and Medicaid bears this out. Mandated reductions in Medicare reimbursement have only shifted higher costs to businesses and workers, without stopping a 12% annual increase in program costs.

We are also concerned about the breadth and scope of some proposals. We believe we should make the changes consistent with our principles over a 5-7 year time frame. In addition we should not tinker with federal programs such as the Indian Health Service, Department of Veterans Affairs and CHAMPUS until we are certain that the reforms are working.

Finally, we are extremely concerned about proposals mandating that all small businesses provide their employees with health insurance. We believe such an action would force many employers to reduce their payrolls to meet this increased cost. These mandates could even force some small businesses to shut down. Everyone loses -- particularly the workers who have lost their jobs, their income, and have no health care insurance, despite the false promise of full coverage by employer mandates.

### Summary

We stand ready to work on a bipartisan basis to achieve major reforms consistent with the principles outlined above. The health care delivery system in our country is extremely complex and there are many details which must be carefully considered. A major overhaul will not happen overnight, but clearly we must move forward as quickly as possible. Our approach does not call for massive new taxes, but instead would cut costs and waste first, and direct these savings toward resolving the access problem responsibly for all Americans. We believe the government's role is to facilitate the transition through health care reform, and to police the system -- not to impose new regulatory or administrative burdens upon Americans.

We look forward to working with others in the Congress and the Administration to iron out the details and put in place a solid, workable plan that will match the quality of our current system with the availability of affordable health care coverage for all Americans.

### Republicans Rejected All Bipartisan Outreach By the Administration

"As Bennett said, 'Dole made it very clear: No bill is the strategy.'"  
[p.500]

"Republicans openly embraced the latest advice of the conservative strategist William Kristol: Oppose any Clinton health reform 'sight unseen.' Now, at every opportunity, they also publicly adopted Kristol's phrase: 'There is no health care crisis.'"  
[p.270]

". . . it was common knowledge that Dole's staff had told Republicans they were *not* to meet with the First Lady. . . One of the senators in the room remembered, 'John Chafee, . . . got up and said to the First Lady, 'Well, to be really frank with you, we just haven't wanted to meet with you until we've got our own plan in order.'"  
[p. 132]

### Republicans Never Wanted To Pass Health Reform

"Bennet recalled, 'All the co-sponsors of Dole-Packwood were prepared to vote against Dole-Packwood, including Dole and Packwood!'"  
[p. 448]

Haynes Johnson & David Broder. The System: The American Way of Politics at the Breaking Point. Little, Brown and Company: Boston, MA; 1996.

## REPUBLICANS ON MEDICARE

*"I was there, fighting the fight, one of twelve, voting against Medicare in 1965 . . . because we knew it wouldn't work."*

-Senator Bob Dole, 1995

*"No, we don't get rid of it [traditional Medicare] in round one because we don't think it's politically smart . . . but we believe it's going to wither on the vine."*

-Speaker Newt Gingrich, 1995

**To pay for a \$245 billion tax cut for the wealthy, the 1995 Dole-Gingrich budget would have cut Medicare by \$270 billion. Today, the Republicans want a \$548 billion tax cut . . . who knows what they will cut from Medicare this time:**

- *"Where on earth does he come up with that kind of dough . . . ? from popular programs, such as Medicare and environmental projections. But candidate Dole knows it's bad politics to admit that now."* Business Week 8/19/96.
- *"You're gonna have to look at Medicare . . . I would never say it if I were him [Dole] until after the election. No way. No way. Absolutely. I mean I'm not running this year so I can say it and tell the truth."*

-Senator Al D'Amato, Dole Campaign Co-Chair, 8/12/96

**The Dole-Gingrich budget would have hurt older Americans, charging them more for Medicare, providing them with a second class health care system.**

- In spite of their claims to the contrary, the 1995 Dole-Gingrich budget would have increased Medicare premiums by \$268 per couple this year alone and by at least \$1700 by 2002.
- The Dole-Gingrich proposal would have cut total Medicare spending by \$2,800 per couple in 2002, compared to current law.
- The Republicans' excessive Medicare cuts would have forced many rural and urban hospitals to close and undermine quality of care.

**President Clinton is defending our values. His balanced budget proves that the Republicans' excessive cuts, premium hikes, and damaging structural changes are not necessary to balance the budget and strengthen the Medicare Trust Fund.**

## FREQUENTLY ASKED HEALTH CARE Qs&As

**Q: How can the Administration claim that the Republican Medicare proposals that the President vetoed are cuts when actual spending per beneficiary would have increased from \$4,900 to \$7,100 between 1996 and 2002?**

A: The Dole-Gingrich budget IS a cut in Medicare. When compared to current law, the Dole-Gingrich plan would have cut spending from \$8,500 per beneficiary under current law to \$7,100 - a \$1,400 cut. In premium increases alone, married Medicare beneficiaries would have had to pay \$1,700 more; they would surely define that as a cut.

**Q: Is it true that there was only a \$7 difference between premiums under the Republican plan and President Clinton's proposal?**

A: There was never only a \$7 difference between premiums proposed by the Republicans and premiums in the President's plan. A true "apples to apples" comparison reveals that their premiums were \$268 higher per couple this year alone and at least \$1,700 higher over seven years.

**Q: What is the President's position on Medicare Medical Savings Accounts (MSAs)?**

A: Although President Clinton has agreed to a limited test of MSAs for non-Medicare beneficiaries, he is concerned that MSAs would have an adverse effect on the Medicare program. The Republicans Medicare MSAs would attract healthier and wealthier beneficiaries, leaving sicker and more costlier beneficiaries in a weakened traditional Medicare program . . . leaving Medicare to "wither on the vine."

**Q: How do you respond to the Republican claim that the Kassebaum/Kennedy bill is really a Republican initiative that the President could have signed three years ago if he hadn't threatened to veto the bill?**

A: That is absolutely preposterous. In the last Congress, Republicans had no desire to pass any health care reform. As Senator Bennett (R-UT) stated, "Dole made it very clear that no bill is the strategy." It was the Republicans who consistently threatened the passage of Kassebaum/Kennedy this year, due to pressure from some insurers, by making it impossible to bring it up for a vote. Even Senator Kassebaum (R-KS) acknowledged that the President's reference to the bill in his State of the Union address and his constant advocacy for it pressured the Republicans to act.

## KEY REPUBLICAN QUOTES ON MEDICARE

**Senator Bob Dole:** "I was there, fighting the fight, one of twelve, voting against Medicare in 1965 ... because we knew it wouldn't work."

American Conservative Union Speech  
10/24/95

**Speaker Newt Gingrich:** "No, we don't get rid of it in round one because we don't think it's politically smart..... But we believe it's going to wither on the vine."

Blue Cross/Blue Shield Association Speech  
10/24/95

**Senator D'Amato:** "If I had my druthers ... I would have said to my distinguished colleagues, both in the House and in the Senate, 'Don't link this business of tax cuts with fixing this badly flawed system. Put it aside."

Senate Finance Committee  
09/26/95

# **REPUBLICAN PLAN ENDS MEDICAID: PUTS MIDDLE-CLASS FAMILIES AT RISK**

- 1. The Republican Medicaid Plan Will Force States to Eliminate Coverage for Millions of Americans, including:**
  - 4.4 million children,
  - More than 900,000 elderly, and
  - 1.4 million people with disabilities.
- 2. The Republican Plan Will Force Families to Choose Between Nursing Home Care for Their Parents and Education for Their Children.**
- 3. The Republican Plan May Force Elderly Spouses Into Poverty.**
- 4. The Republican Plan Will Wipe Out Quality Standards for Nursing Homes and Institutions Caring for the Mentally Retarded.**

## REPUBLICAN PLAN ENDS MEDICAID: PUTS MIDDLE-CLASS FAMILIES AT RISK

**Republican Plan Will Force States to Eliminate Coverage for Millions of Americans.** Medicaid currently covers 36 million Americans and provides middle-class families with protection from the high costs of nursing home care for their parents. In order to pay for their huge tax cut for the wealthy, Republicans propose slashing Medicaid by an unprecedented \$182 billion -- cutting funding to states by 30% in 2002.

*States will be forced to raise taxes, reduce Medicaid coverage, and cut services. According to data from the non-partisan Urban Institute, the GOP cuts will force states to eliminate Medicaid coverage for as many as 8.8 million Americans in 2002, including:*

- 4.4 million children
- more than 900,000 seniors
- 1.4 million people with disabilities

**Republican Plan Will Force Families to Choose Between Nursing Home Care for Their Parents and Education for Their Children.** Medicaid currently is the largest insurer of long-term care, covering *over two-thirds* of all nursing home residents. Without the guarantee of Medicaid, families of elderly and disabled individuals needing long-term care could be stuck with nursing home bills, currently averaging \$38,000 a year. This extra charge to middle-class families may force them to choose between nursing home care for their parents and education for their children. That's a false choice for millions of hard working families. And that's the wrong way to balance the budget.

**Republican Plan May Force Elderly Spouses Into Poverty.** Republicans are turning their backs on the common ground protection that President Reagan signed into law to ensure that seniors do not have to give up everything they own -- their car, their home, and all their savings -- in order to pay for nursing home care for their sick spouse. The GOP plan repeals this protection, putting seniors at risk of *losing their homes and being driven into poverty* by the cost of their spouse's nursing home care. The GOP plan also means that parents of mentally retarded children may be forced into poverty to pay for their children's care in an institution or at home.

**Republican Plan Will Wipe Out Quality Standards for Nursing Homes and Institutions Caring for the Mentally Retarded.** The Republican plan throws away a decade of progress by repealing another common ground law signed by President Reagan that established quality standards for nursing homes and institutions for the mentally retarded. These standards restrict the use of drugs and restraints and require that nurses' aides are properly trained. Under the guise of reform, Republicans would repeal this law and throw away these fundamental protections -- just to pay for their tax cut.

## REPUBLICAN HEALTH CARE PLANS WILL NOT COVER ELDERLY IN POVERTY

**NEWT GINGRICH CLAIMS THAT SENIOR CITIZENS AT THE POVERTY LEVEL, AND BELOW, WILL HAVE ALL OF THEIR PART B PREMIUM PAID FOR -- 100 PERCENT.**

"I must say with some sadness that we are ending this debate in the same spirit of misinformation that has characterized our opponents consistently. The fact is there is a provision in the medigrant program which provides that senior citizens at the poverty level, and below, have all of their Part B premium paid for by the taxpayers, 100 percent."

-- Newt Gingrich  
Congressional Record  
10/19/95  
Page H 10462

### THE FACTS:

- Under current law, Medicaid pays all Medicare premiums, coinsurance, and deductibles for people below 100 percent of poverty (known as "qualified Medicare beneficiaries or "QMBs").
- The House and Senate bills completely eliminate:
  - the requirement that Medicaid pay Medicare coinsurance and deductibles for people below 100 percent of poverty; and
  - the requirement that Medicaid pay Medicare premiums for people between 100-120 percent of poverty.
- Both the House and Senate bills create a set-aside for a portion of the MediGrant funding for Medicare premiums equal to 90 percent of the average spending between 1993 and 1995 on these premiums.
- The Department of Health and Human Services estimates that the set-aside equals about 1.8 percent of total Medicaid spending. This means that states have to spend 1.8 percent of their block grant funds for Medicare premiums.
- **Contrary to the Speaker's claims, in the year 2002, the set-aside amount is estimated to cover only 44 percent -- or \$3.7 billion -- of the amount that is projected to be spent on Medicare premiums (\$8.5 billion) for people in the QMB program.** [This estimated spending includes the impact of the Republican's increase in Part B premiums.]