Coalition for Consumer Protection and Quality in Health Care Reform

The Coalition for Consumer Protection and Quality in Health Care Reform is made up of a diverse group of health care consumer organizations - representing more than 30 million people - with the common goal of a health care system that offers good consumer information, meaningful choice, quality assurance and public accountability.

Coalition Members

American Association of Retired Persons
California Advocates for Nursing Home Reform
Center for Health Care Rights
Center for Medicare Advocacy
Coalition of Advocates for the Rights of the Infirm Elderly
Families USA
The Gerontological Society of America
National Citizens Coalition for Nursing Home Reform
National Committee to Preserve Social Security and Medicare
National Council on the Aging
National Indian Council on Aging
National Osteoporosis Foundation
National Senior Citizens Law Center
Older Women's League

Endorsing Organizations

American Medical Peer Review Association
Foundation for Hospice and Homecare
Healthright
Large State PRO Consortium
National Association of Health Data Organizations
National Association of Protection and Advocacy Systems
Public Citizen Congress Watch
Service Employees International Unions
United Seniors Health Cooperative

Collaborating Organizations

Children Now
Citizen Advocacy Center
Commission on Legal Problems of the Elderly, American Bar Association
National Consumers League
National Council of Senior Citizens
National Hospice Organization
Public Citizen Health Research Group

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Testimony

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For:

Coalition for Consumer Protection and Quality in Health Care Reform

Before:

Subcommittee on Health for Families and the Uninsured
Committee on Finance
United States Senate

Regarding:

Consumer Protection and Quality Assurance

April 29, 1994

Mr. Chairman, members of the Committee, my name is Alfred Chiplin. I am a Staff Attorney with the National Senior Citizens Law Center. I focus my attention on cases involving Medicare, home health care and Older Americans Act issues. Suffice it to say, the Center has many years of experience defending the rights of consumer's of health care and other Federal and state entitlements and services.

Today, I am representing the Coalition for Consumer Protection and Quality in Health Care Reform, a coalition of more than 25 consumer groups. We thank you for providing us with the opportunity to testify today, and congratulate you on your excellent record in health care and in protecting the rights of the disadvantaged.

The Coalition applauds the President's and Congress' all-out effort to reform the health care system. Specifically, we are pleased with the Health Security Act's attention to consumer empowerment through an extensive system of data collection, analysis and dissemination. The administration has also demonstrated its concern for patients rights through the establishment of an ombudsman program, an appeals system and the development of grievance procedures.

It is the Coalition's assessment, however, that additional consumer protections are needed to ensure that health care plans provide high quality care. The linchpin of any national health care system is consumer satisfaction. Reform can work, but only with strong consumer protections to ensure that plans do not contain costs by providing less care than is appropriate.

SUMMARY

I would like to outline briefly our vision of consumer protection in the new health care system. This new system relies on competition between health care plans and providers to drive the cost of care down and quality of care up.

Under any new system, consumers will need easy access to unbiased information to help them make meaningful choices between plans, providers, and coverage options. They will need an advocate or ombudsman to help them understand and navigate through the system and assist with resolving complaints. They will need an appeals process to address the denial, reduction, or termination of benefits and services, and quality issues independent and fair. They will want a grievance procedure for other patient complaints.

The system will need independent quality improvement foundations and quality assurance and public accountability through improved licensing, certification, and accreditation systems, and consumer control of governance structures. There must be guaranteed funding for these programs.

These are the elements of a health care system that is sensitized to the basic fact that the system -- physicians, nurses, pharmacists, other health care professionals, hospitals, and health care plans -- is there to serve those who need care, the consumers.

We do not promote red tape or over regulation, but the burden to ensure consumer protection and prevent poor quality of care falls on the President and Members of Congress. Please do not miss this opportunity to design a consumer- focused system or you will be hearing from your constituents when the system fails.

Today, I would like to address four areas of particular interest to consumers:

I. Consumer Due Process Protections

II. Consumer Information

III. An Independent Ombudsman Program

IV. Quality Improvement and Public Accountability

I. CONSUMER DUE PROCESS PROTECTIONS

Background

The Coalition believes that consumer notice, appeal, and grievance rights -- collectively referred to as consumer "due process" rights -- are essential in any national health care plan. Under a managed care system, health plans and the utilization review systems work to keep the cost of care down. In some instances this will be done at the expense of the medical needs of the enrollee. Therefore, access to an independent and timely appeals process is critical to maintaining quality care for consumers.

Medicare beneficiaries enrolled in Medicare participating HMO's do have some, although inadequate, due process protections. Other enrollees in managed care plans have even fewer protections. Even so, the rights of Medicare enrollees to adequate notice and appeals procedures are honored in the breach.

The following case illustrates the necessity for strong consumer due process protections:

> Mrs. G. is a 71 year old resident of Arizona with multiple health problems including Diabetes, High Blood Pressure, Congestive Heart Failure, Anemia, and a Uremic Bladder. She enrolled in a Medicare contracting HMO, which promised to provide her with all of the health services covered by Medicare as well as additional services such as free physical examinations. Mrs. G. has had many problems since.
>
> Last year her right leg was amputated at the knee after her HMO doctor failed to respond to her complaints of pain in her foot. She is now wheelchair bound.
>
> In August, 1993, Mrs. G. was hospitalized with a blood clot. She was discharged by the HMO from the hospital, although she was still quite sick. Her HMO physician was unable to obtain approval from the HMO for rehospitalization and instead sent her to a nursing home.

The HMO sent her home from their nursing home with an indwelling catheter, without making arrangements for home care or instructing her family in the care of the catheter.

Her attorney wrote to the HMO plan demanding home health services. The plan agreed to provide one home health visit per month to change her catheter, but denied any additional services. Later Mrs. G. was hospitalized again with a serious urinary tract infection. After being discharged she was denied HMO-covered home health services needed to assist with her unskilled care needs until her attorney filed a Motion for Preliminary Injunction.

Until her attorney wrote to the HMO and the Health Care Financing Administration, Mrs. G. never received a notice from the HMO stating that care was being denied, explaining the reasons for denying such care, or describing the availability of an appeals process.

Recommendations

A. Appeals Process

We have attached a copy of generic legislative language that we drafted which is applicable to any reform legislation. The primary issues addressed in this language are notice, procedures for independent administrative review (including expedited review), and access to the courts.

However, the Coalition is generally pleased with the review structures envisioned by the Health Security Act, which is consistent with our White Paper that we request be inserted in the record. We suggest that those structures be considered by your Committee. If you choose to use the Health Security Act's approach, the following are recommendations for improvements.

1. Notice of Appeal Rights

Congress must clarify the circumstances for providing notice to patients when decisions to deny, reduce, or terminate a service or payment have occurred. Specifically, the Coalition recommends that notice provisions of the Act be strengthened to include the following:

* Notices should be triggered automatically when certain benefits, such as hospital, in-patient rehabilitation, nursing home and home health care, have been denied, reduced, or terminated;

* Notices should state the specific reasons for the decision and describe the appeals process available to the patient;

* All plans should be required to provide enrollees with periodic notices of their appeal rights and prominently place notices describing appeal rights in provider waiting rooms.

The Health Security Act should clarify that what the Act refers to as a "claim" includes the review of a decision to deny, reduce, or terminate ongoing services. These vital points are also included in our generic legislative language.

2. Need for Independent Expedited Review

Our experience with clients leads us to conclude that without an expedited review system an appeals system is useless in cases of underservice, urgent care situations, or where critical ongoing services are being terminated or reduced. The appeals system takes months at a minimum. Often managed care enrollees denied needed care do not have months to wait for service. Even short delays in the provision of services, such as home health care rehabilitation services, MRIs, specialty care and surgeries can have harmful and permanent effects. The Health Security Act does call for an expedited review system, but one that is not independent of the managed care plans. The Coalition strongly recommends the following additions to the appeals process:

* All managed care enrollees should have available to them an expedited appeals system operating independently of the managed care plans for denials/delays in treatment that could seriously jeopardize their health or well-being.

* An independent monitoring organization should render a decision on all expedited reviews within 24 hours.

3. Shortening of Appeal Time Period

The Health Security Act gives plans 30 days to make a decision of an initial appeal and an additional 30 days to make a second decision on a request for reconsideration. The Health Security Act also requires that all claimants must go through the initial and reconsideration stages prior to referral to a state Complaint Review Office. The Coalition believes Congress should consider the following options to shorten the appeal process:

* The reconsideration stage of the appeal process should be eliminated, allowing enrollees to directly appeal to the Complaint Review Office following a plan denial of the initial appeal; or the time allowed plans to make initial and reconsideration decisions should be shortened to 15 days each.

4. Plan Coverage of Second Opinions

The Clinton Plan places the responsibility and costs of purchasing second opinions on the beneficiary. This places an unacceptable burden of proof on the beneficiary. For low-income individuals in particular, this burden will negate the appeal right. In response to this problem, the Coalition recommends that:

* The Health Security Act should require plans to pay second opinions for specified conditions/procedures, as determined by an administrative law judge where such opinions are necessary for fair resolution of issues or for the development of the record.

5. Point-of-Service Option -- Out-of-Network Care

The provision of additional information is not enough to protect HMO enrollees in plans that provide poor quality care. The Health Security Act permits consumers to switch plans only once a year, which a number of our members do not think is often enough. Therefore, it is critical that managed care enrollees retain the option of seeking care outside a managed care plan. Specifically, the Coalition strongly recommends that:

* The Health Security Act's requirement that HMO's offer a "point of service option" be retained, and that low-income individuals and persons with rare diseases and disabilities will pay an appropriately reduced coinsurance for out-of-network care.

Attached is legislative language we have drafted to address this issue.

B. Grievance Process

All certified plans must be required to initiate and maintain a grievance process for patient complaints about problems other than denial, reduction, or termination of service or payment. We believe the grievance process should have the following components:

* Oral and written complaints from patients should be investigated by a patient advocate, who will prepare a written report for the plan and the consumer within 15 days;

* The plan's or insurer's grievance committee should issue a decision within 30 days regarding the patient advocate's report. The written decision should be sent to the grievant.

* Grievants dissatisfied with the grievance committee action should be able to obtain a review by a Complaint Review Office.

II. CONSUMER INFORMATION

Background

Currently, health care consumers lack even the most basic information about the quality of care provided by our health care system. The most common question asked by Medicare beneficiaries considering whether to join an HMO is "which one is best." Unfortunately, we

have no answer to this question and Medicare beneficiaries are forced to make their health care choice in a virtual information vacuum.

Moreover, the little consumer information that is collected is of dubious quality. The Health Care Financing Administration (HCFA) and state governments have been extremely lax about HMO data collection in both the Medicare and Medicaid programs. HCFA, for example, collects, but does not analyze Medicare HMO disenrollment data, collects no meaningful utilization or outcome data by plan, and has very loose standards for defining (much less investigating or keeping data regarding) types of complaints received. In short, HCFA collects and provides to the public almost **no** usable quality of care data.

Further, with few exceptions, the state and federal governments and most HMO's are unwilling to provide consumers and their representatives with any quality of care information. In fact, on April 27th *The Washington Post* ran an article revealing the difficult time that the Federal Government is having in getting health care plans to join a nationwide survey of consumer satisfaction which we believe is a critical element of consumer information. Some plans voiced opposition to an independent surveyor and the choice of questions, and wanted the right to block the release of survey results after reviewing the responses. This is indicative of the need for mandated consumer information.

Recommendations

A. Information

The report card data required in the Health Security Act is an excellent first step toward ensuring that health care consumers have the quality of care information needed to make an informed decision. However, the Coalition believes that additional comparative, plan-specific and condition-specific information should be provided to consumers. The list below is only suggestive of the types of information we believe consumers need. For additional suggestions, I refer you to the Coalition's White Paper submitted for the record.

1. Comparative Information

Congress should require the collection and yearly publication of a number of additional comparative quality of care measures, including:

* Results of the consumer satisfaction survey;
* Plan enrollment and disenrollment figures;
* The ratio of complaints/grievances and appeals to plan enrollees;
* Information on plan providers and costs of out-of-plan use;
* Ratio of primary care practitioners to enrollees and the ratio of board certified physicians to non-board certified physicians;
* Information on plan benefits and any limitations on these benefits;

* Individual plan risk-arrangements (financial incentives under which plan health care providers operate); and
* Plan utilization data for selected services, including hospitalization, home health visits, and psychiatric visits adjusted for age, sex and, when possible, health status.

2. Plan-Specific Information

Plans or health alliances should provide all enrollees, upon request, with the following information to help in the selection of a primary care physician or other plan providers:

* Fact sheets on plan physicians--their training, years of practice, board certification, faculty responsibilities, and confirmed disciplinary actions such as repeated malpractice payments; and
* Fact sheets on individual hospitals, home health agencies, laboratories, pharmacies, and other contracted health providers with lists of services and other details .

3. Condition-Specific Information

Plans should be required to provide age, sex and, when feasible, severity adjusted condition- or treatment-specific information and a comparison with similar information for the region, state or nation. For a particular condition/surgery, this data could include:

* Number of surgeries performed (by hospital and by surgeon);
* Death rates within a specified time period;
* Complication rates for specified surgeries (e.g., surgery for prostate cancer); and
* Hospital infection rates (generally) and readmissions for the same condition within a specified time.

To ensure a better protected and informed public and to promote national consistency in data reporting, the Coalition believes that Congress should add greater specificity to the types of consumer information which must be made available.

B. Plan Marketing Controls

The Health Security Act requires alliances to approve all plan marketing materials. The history of both Medicare and Medicaid HMO's provides ample evidence that HMO marketing activities are open to serious abuse, and we believe some entity must monitor this area.

Consumer report cards with outcome and other measures are critical if consumers are to make informed decisions on which health plan to join. However, if controls on marketing

are not adequate, plan marketing activities (including television, radio and print advertisements, celebrity spokespersons, and the actions of individual marketing agents) could undermine the report cards' effectiveness. At a minimum, the Coalition believes that marketing by managed care plans must be carefully scrutinized.

III. AN INDEPENDENT OMBUDSMAN PROGRAM

Background

The Coalition is pleased that the Health Security Act and other health care reform approaches have called for the creation of ombudsman offices to assist consumers with their questions and concerns and to serve as consumer advocates, helping consumers negotiate the system and resolve complaints. It should be noted, however, that as important as an ombudsman program is, it is not a substitute for the appeals process that we have outlined earlier in this testimony.

The Coalition believes, however, that Congress should provide much greater specificity regarding how this program will be designed, and how it can be used by consumers. We also believe that to be truly effective, the program must be adequately financed and operate independently of the plans, alliances, and states.

Recommendations

A. Financing

The Health Security Act includes the option for alliance eligible individuals to designate one dollar of their premium toward an ombudsman program. This approach puts the program in jeopardy from the beginning. Not every enrollee will understand the value of the program until they have a problem and need its services. Further, for the ombudsman program to be effective, it needs a trained, full-time staff supported with steady funding. To ensure an effective ombudsman program, the Coalition recommends that:

* Congress should mandate that a percentage of premiums collected be set aside to cover the costs of the Ombudsman program and other quality improvement and consumer protection systems.

B. Independence

The ombudsman must assist with both plan and alliance-related problems. It is unrealistic to expect the ombudsman to effectively deal with problems that arise within the alliance if it is located there and receives its funding from it. To ensure an effective consumer advocacy Ombudsman program, the Coalition recommends that:

* The Ombudsman program be established as a non-profit consumer organization totally separate and independent of alliances, plans, providers, and purchasers.

The attached legislative language provides a framework for this new health care ombudsman.

IV. QUALITY IMPROVEMENT AND PUBLIC ACCOUNTABILITY

Background

The Consumer Coalition believes that consumer information, consumer protection, and quality improvement programs must be accountable to the public, independent of providers and payers of health care, and free of potential conflicts of interest. There has been proposed an excellent foundation for independent monitoring of quality through the establishment and functions of the National Health Board, National Quality Management Program, and National Quality Management Council at the federal level and the alliance quality of care reporting requirements at the state and local level.

Quality of health care is measured in three ways: structure, process, and outcome. All three complement each other and are needed if we are to adequately protect consumers in any managed care plan.

Several proposals provide for information on outcome measures. However, they do not include the establishment of consumer-based independent entities to monitor and improve the quality of care provided by plans. We must also ensure public accountability and adequately define the role of states in ensuring that consumers are protected through strong licensing and certification and enforcement of quality protections.

Recommendations

A. Quality Improvement Foundations

Any health care reform proposal should include an external quality review entity, independent of the payer-based alliances and provider-based plans to monitor and improve quality in each state, but not run by the state itself. For purpose of reference, we call these entities "Quality Improvement Foundations" or QIFs.

The National Quality Management Council would provide competitive grants to create one QIF in each state. Funding would come from the National Health Board through an amount designated from each premium. The QIF would be governed by a consumer majority board, which includes others who are experts in a variety of health and quality research fields.

Each QIF would perform a variety of quality monitoring and improvement functions, including:

* Performance of expedited quality of care reviews:
* Data analysis and data quality testing;
* Dissemination of information on successful quality improvement programs;
* Technical assistance to plans and alliances;
* Development of and support for quality improvement activities;
* Provision of consumer information beyond the report card;
* Monitoring and feedback to plans on adherence to practice guidelines;
* Analysis of plan utilization measures; and
* Quality assurance by providing:
  -- information to consumers
  -- feedback to licensing, certification, and accrediting entities and the National Quality Management Council.

B. Medicare Quality Oversight

The Health Security Act proposes the termination of the Medicare Peer Review Organizations. Although the Coalition believes that the functions of these organizations could be strengthened, we oppose their elimination and understand that the Administration no longer supports it either.

C. Consumer Representation

One of the most effective ways to ensure public accountability is to mandate consumer representation on advisory boards. The Coalition is pleased that the Health Security Act recognizes the importance of consumer involvement by providing for consumer representation on some of the boards and advisory councils specified in the bill. However, we believe that the consumer role in the governance of the health care system must be strengthened. Consumers are in a unique position to advocate for a system that delivers high quality care -- unlike payers or providers of care, they are immediately affected by any changes in the quality of care delivered and are free from potential conflicts of interest.

The Coalition recommends a stronger consumer role including:

* Consumer control of the boards of any regional health alliances and corporate alliances (the Act currently provides for no consumer representation on corporate alliances.)

* Consumer representation on the National Quality Management Council and the National Long-Term Care Insurance Advisory Council and other boards and commissions established by Congress; and

* Funds to train and provide technical assistance to consumer representatives.

D. State Role and Licensing, Certification and Enforcement

The Coalition supports improving the effectiveness of licensing, certification and accreditation entities. Any reform bill and its implementing regulations should include provisions for strengthening the federal and state roles in licensing, certification, and accreditation, including:

For professional licensing boards (see attached legislative language) --

* Providing incentives through grants to increase the role of consumers on boards to at least 50 percent;

* Mandating that all fees paid by licensees be dedicated to the operation of the board; and

* Publicizing information regarding disciplinary actions.

CONCLUSION

Senators, we believe that proponents of the status quo in our health care system will distort the facts and attempt to scare consumers into believing that quality will suffer under a new health care system. We believe that the mechanisms that we are recommending will protect quality further and provide consumers with the information, advocacy, due process rights, quality improvement, and public accountability that will make this reform better for American consumers of health care.

The Coalition is grateful to Senator Riegle and his staff for holding this hearing and focusing your attention on these critical issues. We look forward to working with you in the future.

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[This amendment would strike Sec. 5008 of H.R. 3600, and replace it with the following new language for that section.]

SEC. 5008. HEALTH QUALITY IMPROVEMENT FOUNDATIONS.

(a) Establishment. The National Quality Management Council shall establish a program of grants to eligible organizations to serve as Health Quality Improvement Foundations to perform the duties specified in subsection (d) for the population of each State, and shall oversee the operation of such Foundations.

(b) Eligibility.

(1) In General.-- To be eligible for a grant under this section, entities must demonstrate compliance with the criteria of paragraphs (2) through (5).

(2) Governing body.--
(A) In General.-- Each entity shall be governed by a board consisting of health professionals and public members, no fewer than fifty-one percent (51%) of whom shall be public members.

(B) Definition.-- For purposes of this section, the term "public member" means an individual who resides in the State and is a person of integrity and good reputation who has lived in the State for at least five years immediately preceding appointment to the Board, and has never been authorized to practice a healing art, and has never had a substantial personal, business, professional, or pecuniary connection with a healing art or with a medical education or health care facility, except as a patient or a potential patient.

(3) Staffing.-- Each entity shall be staffed by individuals expert in quality improvement, and experts in the fields of epidemiology, measurement of risk adjusted health outcomes, use of clinical practice guidelines, health services data analysis, and provider education.

(4) Contract with Academic Health Center.--
(A) Each entity shall have a contract with an academic health center to assist in fulfilling the duties described under subsection (d).

(B) For purposes of this paragraph, an 'academic health center' means an academic health center which is affiliated with a medical school.

(5) Conflict of interest.--
(A) An entity seeking receive a designation under this section

shall be considered a 'disclosing entity' for purposes of section 1124 [42 USC 1320a-3] of the Social Security Act;

(B) Such entity may not --

(i) directly or indirectly (as determined by the regulations promulgated under section 1124(a)(3) of the Social Security Act) possess an ownership interest of 10 percentum or more in a health care facility, a health plan, or association of such;

(ii) own a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by a health care facility, health plan, association of such, or any of the property or assests thereof, which whole or part interest is equal to or exceeds 10 percentum of the total property and assets of the facility, plan, or association; or

(iii) utilize officers or members of the governing body more than 10 percent of whom are the officers or members of the governing board of one or more health facilities, plans, or associations).

(c) Grants to entities.

(1) In General.-- The Council shall select, through a competitive grantmaking process, no more than one entity to serve as a Health Quality Improvement Foundation in each State, and may designate one entity to serve multiple contiguous States.

(2) Preferences.-- In making its designation, the Council shall give preference to an entity --

(A) which can fulfill the duties described under subsection (d) for enrollees of health plans certified under section 1203 as well as enrollees of Title XVIII of the Social Security Act; and

(B) for which the primary place of business is located in the State within which the functions of the Foundation will be conducted, or, if one entity is to be designated to serve multiple States, preference shall be given to an entity for which the primary place of business is located in one of the States.

(3) Scope of work.-- Each grant with an entity under this section shall be pursuant to an agreement providing that -

(A) the entity shall perform the duties set forth in this section for the benefit of --

(i) enrollees in health plans certified under section 1203; and

(ii) unless the entity is subject to the transition rule under subsection (e), individuals enrolled under Title XVIII of the Social Security Act;

(B) the Council shall have the right to evaluate the performance of the entity in carrying out the functions specified in the grant;

(C) the grant shall be for a term of four years and shall be renewable, based upon evidence of successful quality improvement performance, without reopening the competitive selection process, except that an entity subject to subsection (e)(3) shall have term(s) limited to two years and shall be subject to competitive process at the end of each contract period;

(D) if the Council decides not to renew a grant with a Foundation, the Foundation shall be notified of the decision at least 180 days prior to the expiration of the grant term, and shall be afforded an opportunity to present information for the purposes of appeal of the decision not to renew the grant;

(E) based on a finding by the Council that the organization does not meet the requirements of this section, the Council may terminate the grant prior to its expiration upon 180 days notice, during which notice period the Council shall provide the Foundation an opportunity to appeal the Council's finding before a panel of representatives of Foundations convened by the Council;

(F) the entity may terminate the grant upon 180 days notice to the Council; and

(G) the amount of the grant to be allocated under a grant shall consist of a sum necessary to perform the duties under subsection (d), which may be augmented with additional funds for the performance of research described under section 5007 by a Foundation selected by the Council for exemplary performance and the merit of research proposals submitted.

(d) Duties. A Health Quality Improvement Foundation shall carry out the following duties in the State in which the Foundation operates:

(1) Quality improvement.-- Collaboration with physicians and other health care professionals in ongoing efforts to improve the quality of health care provided to individuals in the State, giving priority to health conditions and interventions which are likely to

produce the greatest impact in preventing or reducing morbidity, mortality and functional impairment.

(2) Oversight.-- Analyze data obtained under sections 5003, 5004, and health care information furnished under 5101(e) pertaining to health care delivered in the State, for the purpose of --

(A) identifying opportunities for quality improvement;

(B) documenting that such improvement is being realized;

(C) auditing samples of such information and its source documents to assure the information is valid, reliable, and comparable between plans, and to inform recommendations for improving the validity, reliability and comparability of the information.

(3) Technical assistance.-- Provide technical assistance to health plans and providers, including--

(A) feedback of information on patterns of health care delivery and outcomes;

(B) assistance in fulfilling the data reporting requirements of Section 5103;

(C) assistance in the development of patient education systems that enhance patient involvement in decisions relating to their health care;

(D) entering into agreements with selected health plans for the purpose of offering educational programs to physicians and other health care professionals.

(4) Annual report.-- Issue an annual report to the Council and to the public concerning--

(A) recommendations for improving the utility of clinical practice guidelines as a means of identifying opportunities for improvement and bringing about quality improvement;

(B) recommendations for improving the reliability and validity of the health care information described in section 5101(e), the national measures of quality performance described in section 5003, and consumer survey data obtained under section 5004;

(C) selected measures of the health care status of the population of the State, including a description of activities underway and progress achieved; and

(D) a description of activities undertaken during the preceding year pursuant to subsection (b)(3) and subsection (d)(3)(D).

(5) Multi-plan collaborations.-- Sponsor of statewide and other collaborations involving multiple plans or providers to identify opportunities for quality improvement, and to bring about improvements in health care.

(6) Referrals.--
(A) Except as provided in subparagraph (C), if the health quality improvement foundation finds, after affording reasonable opportunities for improvement, that a provider or plan--

(i) continues to furnish services characterized by underuse, overuse or poor technical quality, and

(ii) is unwilling or unable to successfully engage in quality improvement activities related to the services described in subparagraph (A),

the Foundation shall provide notice of such finding to the officials and entities described in subparagraph (B), and shall make available to such officials and entities upon request data and information relied upon by the Foundation in making the referral.

(B) A finding under subparagraph (A) shall be forwarded --

(i) if the finding pertains to a health plan, to the appropriate alliance(s), accreditation organization(s), State officials responsible for certification under section 1203, and the public;

(ii) if the finding pertains to a provider, to the appropriate State health facility or State professional licensure board(s) and health plan(s); and

(iii) if the finding arises from care provided to enrollees under Title XVIII of the Social Security Act in a State subject to subsection (e)(3), to the organization with which the Secretary of HHS has a contract under section 1153 of the Social Security Act.

(C) If a Foundation identifies a provider who poses an imminent risk to the health of patients receiving or likely to receive health care from the provider, the Foundation shall immediately notify the appropriate authorities listed under subparagraph (B).

(e) Transition rule.

(1) In General.-- The first Health Quality Improvement Foundation to be designated in any State where a Utilization and Quality Control Peer Review Organization has a contract under section 1153 of the Social Security Act shall not commence operations until the expiration or termination of the contract in effect on the date of enactment.

(2) Deeming.-- Except under circumstances described in paragraph (3), an entity designated as a Health Quality Improvement Foundation under this section shall be deemed to have an agreement with the Secretary of Health and Human Services under section 1153 of the Social Security Act, and shall receive all funds designated by law for that purpose in the State.

(3) Temporary designation.-- In a State where no entity submits a qualifying application under this section to serve all of the enrollees described in subsection (c)(3)(A), the Council may designate an entity to fulfill the duties described in subsection (d) only for individuals enrolled in plans certified under section 1203 until such time as an entity does submit a qualified application to perform these duties for all individuals in the State.

(f) Limitation on liability. No organization having a grant with the National Quality Management Council under this part and no person who is employed by, or who has a fiduciary relationship with any such organization, or who furnishes professional services to such organization, shall be held by reason of the performance of any duty or activity authorized pursuant to this part to have violated any criminal law, or to be civilly liable under any law of the United States or of any State (or political subdivision thereof) provided that the performance of such duty or activity was not conducted in bad faith.

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DRAFT LEGISLATIVE LANGUAGE

* Due Process Provisions for Health Care Reform
* Due Process Amendments to the Health Security Act
* Out-of-Network Coverage Amendments to the Health Security Act
* Consumer Information Provisions for Health Care Reform
* Ombudsman Program Provisions for Health Care Reform
* Health Professional Licensing Board Provisions

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DUE PROCESS PROVISIONS FOR HEALTH CARE REFORM

SEC. _____. INDIVIDUAL APPEAL RIGHTS

(a) Appeals Process.-- An appeals process shall be established for patients for whom health care coverage, services, or referrals have been denied, reduced, terminated, or otherwise adversely affected. The appeals process shall include notice, administrative review, and judicial review.

(b) Subsidies and Premium Amounts.-- With respect to the denial, reduction, or termination of a subsidy or of a determination of a premium amount, the Secretary shall develop a notice and appeals procedure that provides the protections available to individuals the same as provided in Title XIX of the Social Security Act.

(c) Notice.-- Written notice must be given to the patient by the insurer or health plan as follows --

(1) promptly after decisions made by physicians and other service providers, as well as plan administrators and insurers, that result in --

(A) denial or termination of a specific service, referral, or coverage requested by the patient verbally or in writing;

(B) termination or reduction of coverage or provision of a course of treatment or ongoing series of services such as nursing home or outpatient therapy services; or,

(C) patient dissatisfaction expressed verbally or in writing with the type or extent of services or coverage being provided.

(2) such notice shall include --

(A) an explanation of the specific facts and law underlying the decision to deny, reduce, terminate or otherwise fail to provide services, coverage, or referral;

(B) a description of the process for appealing such decision sufficient to allow the patient to initiate an appeal and submit evidence in support of his position to the decision-maker.

(d) Administrative Appeals.-- An administrative appeals process shall be made available to the claimant as follows --

(1) an informal review shall --

(A) be held within 5 days of request by a claimant;

(B) be performed by the health plan or insurer;

(C) result in a written decision setting out the basis in fact and law within 10 days of request by the claimant;

(2) an administrative hearing shall --

(A) be held within 30 days of request by a claimant;

(B) be conducted by an independent administrative law judge;

(C) include evidence by an independent medical expert provided for the claimant at the plan's expense when the administrative law judge determines that such medical evidence is necessary for fair resolution of the issues or for development of the record;

(D) provide claimants the right to present supporting evidence, to subpoena and cross-examine adverse witnesses, and to have access to one's medical records;

(E) result in a written decision setting out the judge's findings of fact and conclusions of law within 30 days of the hearing.

(3) an expedited appeal shall --

(A) be available when denial, reduction, delay, or termination of the service, coverage, or referral at issue --

(I) would create a risk of serious or permanent harm to the patient; or

(II) involves an ongoing series of services such as inpatient hospital or nursing home care, therapies, or home health services, such ongoing series of services to be continued through the completion of the expedited appeals process described herein.

(B) include informal review as provided in sub-paragraph (1), above, completed within 24 hours of a request;

(C) provide an administrative hearing decision, as provided in sub-paragraph (2), above, within 3 days of a request.

(4) in order to prevail in an appeal, the health plan or insurer must produce sufficient evidence to justify its decision denying, reducing or terminating the service, coverage, or referral at issue.

(5) failure to complete an administrative decision within the specified time limits will allow the claimant, at his or her option, to proceed immediately to the next stage in the appeals process.

(6) when the claimant prevails in an administrative appeal, the health plan or insurer shall be required to pay the claimant's reasonable costs, and reasonable attorney's and expert's fees.

(e) Judicial Review. -- review of the decisions of the administrative law judge shall be available at the claimant's option in --

(1) an appropriate state court, or

(2) the federal district courts of the United States as follows --

(A) in all cases raising issues as to the validity of statutes, administrative rules, and practices;

(B) in all other cases involving health care coverage, referrals, or services valued at $1,000 or more, except that this jurisdictional amount shall be waived for appeals by indigent claimants;

(3) nothing in this Part shall be construed to require exhaustion of administrative remedies that would be futile or that would create a risk of irreparable injury to the claimant; and

(4) the prevailing claimant shall be entitled to reasonable attorney's fees, reasonable expert witness fees, and other reasonable costs relating to such action.

(f) Pre-emption.-- nothing in this Part shall be construed to pre-empt other consumer rights or remedies available under state or federal law, including common law.

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DUE PROCESS AMENDMENTS TO THE HEALTH SECURITY ACT

Subtitle C -- Remedies and Enforcement

PART 1

Amend sec. 5201 to require that notice be given to enrollees whenever hospital, nursing home, and home health services are terminated and whenever a health plan or provider does not prescribe services that are generally prescribed for the enrollee's condition.

Amend sec. 5201 to provide that enrollees are authorized to obtain second opinions from non-plan physicians when their claims have been denied.

Amend sec. 5201 to require notice of disposition of claims for services within 5 days after the date of submission of the claim.

Amend sec. 5201 to state that enrollees whose plans continue to refuse a service without providing timely notice of denial can obtain the service out of plan and require the plan to pay for it.

Amend sec. 5204 to include a 120 day time limit for a hearing decision by the Complaint Review Offices.

Amend sec. 5204 to state that in appeals the burden of proof rests on the plan.

Amend sec. 5206 to specifically state that provisions for civil monetary penalties include a private right of action.

Amend sec. 5216 to require completion of the mediation proceedings for the Early Resolution Program within 60 days.

Amend sec. 5205 to clarify that jurisdiction exists for review of Health Plan Review Board decisions regardless of monetary limitations for cases involving constitutional and statutory interpretation.

PART 2

Amend the Act to include authorization for private enforcement actions against the plans.

Amend sec. 5241 to eliminate the requirement that facial constitutional challenges be brought within one year of enactment.

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OUT OF NETWORK COVERAGE AMENDMENT TO THE HEALTH SECURITY ACT

Amend Section 1132, "LOWER COST SHARING," by adding underlined language:

(b) OUT-OF-NETWORK COINSURANCE PERCENTAGE.--

(1) In general. -- The National Health Board shall determine a percentage referred to in subsection (a)(4). The percentage

(A) may not be less than 20 percent; and

(B) shall be the same with respect to all out-of-network items and services that are subject to coinsurance, except as provided in paragraph (2).

(2) Exceptions. --

(A) Higher coinsurance services.-- The ~~National Health Board~~ Secretary may provide for a percentage that is greater than a percentage determined under paragraph (1) in the case of an out-of-network item or service for which, under the higher cost sharing schedule described in section 1133, the coinsurance is greater than 20 percent of the applicable payment rate.

(B) People with special health care needs. -- For families with family adjusted income at or below 250% of the applicable poverty level, based on actual family size, the Secretary shall provide for amounts that do not exceed by more than 25% the amounts such families would pay for in-network services, for individuals who (i) have rare or complex diseases or conditions, as defined by the Secretary, including those described in Sec. 527(a)(2)(A) of the Federal Food Drug, and Cosmetic Act, or (ii) are disabled as defined under Titles II or XVI of the Social Security Act or eligible for benefits as incapacitated under Title IV-A of such Act, during the period when they are determined to be disabled or incapacitated.

(C) Low-income people. -- In the case of approved families (as defined in section 1372(b)(3)), the Secretary shall provide for amounts such families would pay, in addition to the amounts such families would pay for in-network services. Such amounts may distinguish among different groups of approved families, shall assure adequate access to necessary out-of-network services, and shall not exceed those established under subparagraph (B).

(D) General provisions. -- Deductibles and increased premiums shall not apply to individuals described in sub-paragraphs (B) and (C) based on their election of the point of service option.

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CONSUMER INFORMATION PROVISIONS FOR HEALTH CARE REFORM

Rename Sec. 5101(a) as Sec. 5101(a)(1).

Insert the following after Sec. 5101(a)(1):

5101(a)(2) Not later than six months after the date of the enactment of this Act, the Secretary shall develop initial guidelines for a "Consumer Guidebook" for plan selection and use, and will mandate specific information to be provided to consumers in the guidebook, which will be readily available to every consumer in an appropriate format to meet the communication needs of individuals. The Consumer Guidebook will include at a minimum:

(i) Plan-Specific Descriptions, presented in a comparative format, including general information about the health care system, benefits package including any limitations on services, how to appeal a health care decision, how to resolve complaints, how to contact a health ombudsman program, risk arrangements within the plan, referral and incentive arrangements and plan financial data.

(ii) Plan-Specific Quality Report Cards, including quality indicators reflecting a common set of performance measures and enrollee satisfaction which compare the plans, providers, and practitioners in a given region and, when appropriate, provide national averages for comparison. At a minimum, the following areas should be included:

Preventive Care
Indicators of undesired or unplanned occurrences
Utilization of services related to service policy
Consumer Satisfaction (obtained from the national consumer satisfaction survey)
Membership statistics

5105(a)(3) Not later than six months after the date of the enactment of this Act, the Secretary shall promulgate regulations defining additional information that shall be available to consumers upon request, including, but not limited to the following:

(i) Provider and Practitioner Specific Descriptive Information to help consumers choose a plan based on the background of specific practitioners or services of a hospital. Information in this section should be written in a standardized format and include at a minimum:

the plan's unique features set apart from items that the plans must contain;

fact sheets on each of the physicians in the plan; and
fact sheets about home health services, hospitals, laboratories, out-patient services, nursing home skilled care and other contracted health facilities.

(ii) Condition-Specific Provider and Practitioner Report Cards, including enrollee surveys to help guide the consumer to the most appropriate specialist or hospital for treatment of a specific condition. Included in this information should at a minimum be hospital and physician specific practice profiles and outcomes data on particular procedures or conditions adjusted for severity.

Amend Sec. 5101(e) by adding the following:

(12) Any information necessary to collect to provide consumers with information described in Sec. 5101(a)(2) of this Act.

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OMBUDSMAN PROGRAM PROVISIONS FOR HEALTH CARE REFORM

SEC. ____ DEFINITIONS

As used in this chapter:

(1) OFFICE. -- The term "Office" means the office established in section _____.

(2) OMBUDSMAN. -- The term "Ombudsman" means the individual described in section _____.

(3) LOCAL OMBUDSMAN ENTITY. -- The term "Local Ombudsman entity" means an entity designated under section ____.

(4) PROGRAM. -- The term "program" means the Health Care Ombudsman program established in section ____.

(5) REPRESENTATIVE. -- The term "representative" includes an employee who represents an entity designated under section ____ and who is individually designated by the Ombudsman.

(6) INDIVIDUAL. -- The term "individual" means an individual who participates in the health care system.

SEC. ____ HEALTH CARE OMBUDSMAN

(a) ESTABLISHMENT. --

(1) IN GENERAL. -- In order to be eligible to receive a grant under section ____from funds under section ____, an organization shall, in accordance with this section --

(A) establish and operate an Office of the Health Care Ombudsman; and

(B) carry out through the Office a Health Care Ombudsman Program.

(2) OMBUDSMAN SELECTION DESIGNATION PROCESS.-- Entities shall be selected to serve as an Ombudsman through a competitive grant making process.

(A) The Secretary of Health and Human Services shall designate, confer appropriate authority to, enter into a grant arrangement with an Ombudsman in each state. The Secretary shall negotiate a proposed grant which the Secretary determines will be carried out by such organization in a manner consistent with the efficient and effective administration of this section.

(i) Preference shall be given to private, not-for-profit organizations that represent a broad spectrum of the diverse consumer interests in the state.

(B) The Secretary shall not enter into a grant under this part with any entity which is, or is affiliated with, (through management, ownership, or common, control), a health care facility, managed care organization/network, organizations licensing or certifying health care services, health or corporate alliances, or association of such, within the area served by such entity or which would be served by such entity if entered into a grant with the Secretary under this part.

(C) Each grant with an organization under this section shall provide that --

(i) the organization shall perform the functions set for in this section;

(ii) the Secretary shall have the right to evaluate the quality and effectiveness of the organization in carrying out the functions specified in the grant;

(iii) the grant shall be for an initial term of four years and shall be renewable thereafter based upon favorable performance without reopening the competitive selection process;

(iv) if the Secretary intends not to renew, the organization shall be notified of the decision at least 180 days prior to the expiration of the grant term, and shall accord the organization an opportunity to present information for the purposes of appeal of the intent by the Secretary not to renew the grant;

(v) the organization may terminate the grant upon 180 days notice to the Secretary;

(vi) the Secretary may terminate the grant prior to the expiration of the grant upon 180 days notice if the Board determines that the organization does not meet the requirements of the section or if the organization fails substantially to carry out the grant. Appropriate appeals mechanisms, including the establishment of a panel of peers, shall be developed by the Secretary to implement this section.

(D) Financing. In determining the amount of money to be allocated to each Ombudsman to carry out the duties defined in subsection (c), consideration shall be given to the establishment of core funding (based on population, geographic considerations, and other factors determined by the Secretary), with additional funds to be awarded to those entities selected on the basis of performance and innovation in the carrying out of their responsibilities.

(3) PERSONNEL.--

(A) The Ombudsman, staff, and other representatives of the Health Care Ombudsman Program shall meet standards for experience, expertise, and training as specified by the Secretary.

(B) The HCOP shall have adequate legal counsel available to --

(i) provide advice and consultation needed to protect the health, safety, welfare and rights of individuals with respect to health care; and

(ii) assist in the performance of the official duties of the HCOP;

(iii) provide representation to any representative of the HCOP against whom suit or other legal action is brought or threatened to be brought in connection with the performance of the official duties of the HCOP; and

(iv) assist in pursuing administrative, legal, and other appropriate remedies on behalf of individuals with respect to health care.

(4) FUNCTIONS. -- The Ombudsman shall serve on a full-time basis, and shall, personally or through representatives of the Office --

(A) identify, investigate, and resolve complaints that --

(i) are made by, or on behalf of, individuals; and

(ii) relate to action, inaction, or decisions of providers of health care services and public or private agencies involved in the delivery, funding, or regulation of health care.

(B) provide information, referral and assistance to individuals about means of obtaining health coverage and services;

(C) identify, investigate, publicize, and promote solutions to practices, policies, laws, or regulations that may adversely affect individuals' access to quality health care, including but not limited to practices relating to:

(i) marketing of health care plans;

(ii) availability of premium subsidies;

(iii) accessibility of services and resources in traditionally underserved areas;

(iv) adequacy of funding to traditionally underserved areas through community rating and risk adjustment

(D) ensure that the individuals have timely access to the services provided through the Office and that the individuals and complainants receive timely responses from representatives of the Office to complaints;

(E) represent the interests of the individuals before governmental agencies and seek administrative, legal, and other remedies to protect the health, safety, welfare, and rights of the individuals;

(F)(i) analyze, comment on, and monitor the development and implementation of Federal, State, and local laws, regulations, and other governmental policies and actions that pertain to the health safety, welfare, and rights of the individuals, with respect to the adequacy of health care facilities and services in the State;

(ii) recommend any changes in such laws, regulations, policies and actions as the Office determines to be appropriate; and

(iii) facilitate public comment on the laws, regulations, policies, and actions;

(G)(i) provide for training representatives of the Office;

(ii) promote the development of citizen organizations, to participate in the program; and

(iii) provide technical support for the development of consumer and citizen organizations to protect the well-being and rights of individuals; and

(H) exercise such other powers and functions as the Secretary determines to be appropriate.

(5) POLICIES AND PROCEDURES.-- The Secretary shall establish policies and procedures for the operation of HCOPs, including but no limited to polices and procedures to --

(A) ensure optimal coordination among HCOPs;

(B) collect and make available nationally uniform and useful data regarding problems and complaints;

(C) ensure that representatives of the HCOP shall have --

(i) access to health care facilities and individuals.

(ii) appropriate access to review the medical and social records of an individual, if the representative has the permission of the individual, or the legal representative of the individual;

(iii) access to the administrative records, policies, and documents, to which the individuals have, or the general public has access, of health care facilities; and

(iv) access to and, on request, copies of all licensing, certification, and data reporting records maintained by the State or Federal government with respect to health care providers.

(D) protect the identity of any complainant or other individual with respect to whom the Program maintains files or records;

(E) ensure that no individual or organization performing functions of the HCOP has --

(i) a direct involvement in the licensing, certification, or accreditation of a health care facility, a health care plan, or a provider of a health care plan, or a provider of a health care service;

(ii) does not have a direct ownership or investment interest in a health care facility, a health care plan, or a health care service;

(iii) is not employed by, or participating in the management of, a health care service, facility, or plan; and

(iv) does not receive, or have the right to receive, directly or indirectly, remuneration (in cash or in kind) under

compensation arrangement with an owner or operator of a health care service, facility or plan.

(F) establish and implement minimum qualifications and training requirements for personnel, including volunteers;

(G) promote optimal coordination between the HCOP and other citizens advocacy organizations, legal assistance providers serving low-income persons, the State Long-Term Care Ombudsman Program, and protection and advocacy systems for individuals with disabilities established under --

(i) part A of the Developmental Disabilities Assistance and Bill of Rights Act (42 USC 6001 et. seq.);

(ii) the Protection and Advocacy for Mentally Ill Individuals Act of 1986 (42 USC 10801 et. seq.); and

(iii) the Americans with Disabilities Act.

(6) DESIGNATION OF LOCAL OMBUDSMAN ENTITIES AND REPRESENTATIVES. --

(A) DESIGNATION. -- In carrying out the duties of the Office, the Ombudsman may designate entities as a local Ombudsman entities, and may designate employees to represent the entities.

(B) ELIGIBILITY FOR DESIGNATION. -- Entities eligible to be designated as local Ombudsman entities, and individuals eligible to be designated as representatives of such entities, shall --

(i) have demonstrated capability to carry out the responsibilities of the Office;

(ii) be free from conflicts of interest;

(iii) in the case of the entities, be public or non-profit private entities; and

(iv) meet such additional requirements as the Ombudsman may specify.

(7) CONSULTATION. -- In planning and operating the program, the HCOP shall conduct annual public hearings to get the views of the general public and providers of health care.

(8) ANNUAL REPORT. -- The Secretary shall mandate the collection of information and prepare an annual report --

(A) describing the activities carried out by the HCOPs in the year for which the report is prepared;

(B) containing and analyzing the data collected by the HCOPs;

(C) evaluating the problems experienced by, and the complaints made by or on behalf of, individuals;

(D) containing recommendations for protecting the health, safety, welfare, and rights of individuals with respect to their health care;

(E) analyzing the success of the program and barriers that prevent the optimal operation of the program; and

(F) providing policy, regulatory, and legislative recommendation to solve identified problems.

(9) Analyze, comment on, and monitor the development and implementation of Federal, State, and local laws, regulations, and other government policies and actions that pertain to health care facilities and services, and to the health, safety, welfare, and rights of individuals, in the State, and recommend any changes in such laws, regulations, and policies as the Office determines to be appropriate;

(10) Provide such information as the office determines to be necessary to public and private agencies, legislators and other persons, regarding --

(A) the problems and concerns of individuals; and

(B) recommendations related to the problems and concerns.

(11) LIABILITY.-- No representative of HCOPs shall be liable under State or Federal law for the good faith performance of official duties.

(12) FUNDING.-- The National Health Board will provide funding for the HCOPs by assessing each health care premium an amount to be determined by the National Health Board. The Secretary shall provide the necessary funding to carry out this Section prior to the Board's funding of this Section.

(13) Nothing in this Section shall be construed to limit the rights of individuals to use the grievance and appeals processes in this Act.

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HEALTH PROFESSIONAL LICENSING BOARD PROVISIONS

Purpose - It is the purpose of the Congress in this Section to help the states protect the public health and safety by instructing the Secretary of Health and Human Services to award grants-in-aid to health professional licensing boards that conform to the criteria set forth in this title and the implementing regulations promulgated by the Secretary.

Section One -- To be eligible for a grant, a health professional licensing board shall file a plan (certified by the Governor) with the Secretary showing how the board will meet the following criteria:

1. Composition of licensing boards

At least 51% of the members of the licensing board shall be "public" or "consumer" members.

2. Funding

One hundred percent (100%) of the fees paid by licensees to obtain and renew their licenses shall be dedicated exclusively to finance the operation of the board that issues their licenses.

3. Complaint/Report Prioritization and Case Management

The Board must follow a complaint prioritization system that gives the highest priority to allegations of substandard care and that sets reasonable time limits (to be determined by the Secretary) for the investigation of high priority complaints and reports. The board's procedures must ensure that no complaint will be dismissed by the staff without the approval of the board.

4. Timely, Open Disciplinary Proceedings

Disciplinary proceedings shall be completed within a reasonable time frame (to be determined by the Secretary) and shall be conducted in the Sunshine. All voluntary settlements must be approved by the board, in open session.

5. Dissemination of Disciplinary Action Reports

At the time the board determines there is probable cause that a licensee has violated the licensure statue, this information shall become public, including the name of the licensee, the nature of the alleged violation, and the date of the

public hearing. All final board actions shall be widely publicized, including the name of the licensee, the nature of the violation, and the nature of the disciplinary action. Boards in professions included in the National Practitioner Data Bank shall report to and query the NPDB as a routine part of the investigative and disciplinary process.

6. Publication and Dissemination of Annual Report

An annual report containing operating statistics and other reasonable information documenting board performance (to be determined by the Secretary) shall be made available at no cost to the public at large.

7. Prohibition on Unjustified Restrictions

No professional licensing board may, through mandate, board rules and regulations, or otherwise, restrict the practice of any class of health professionals beyond what is justified by the skills and training of such professionals.

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DETAILED SPECIFICATIONS	
. **Structure**	· Each health plan would offer two benefit packages, a basic package and a standard package. · Employers would be required to pay 80% of the average premium for the basic benefit package. Employers could pay more (toward the standard package or for supplemental benefits). · Families would be required to have at least the basic package. · All families, including families working for exempt employers, could choose either package. Families would pay the difference between the basic and standard package (without subsidies, although employers may contribute).
. **Benefit package; phase-in**	Two benefit packages, a standard package and a basic package. Basic package phases-up to standard package over five years. Standard package: · HSA benefit package (with 5% reduction). ▸ FFS and HMO packages as in HSA, with 5% reduction as in Energy and Commerce Staff Draft. Basic package (still under development): · [20%][1] lower value than standard package. ▸ FFS package with higher (e.g., $1500 – $2000) hospital deducible and higher (e.g., 25%) coinsurance; reduce value of other benefits through higher cost sharing or limits. Preserve preventive care (either with minor copayments or put in the wrap package for children). ▸ HMO package would closely resemble FFS package, with copayments rather than coinsurance. · Federal deficit reduction targets would be incorporated into law. Annual reviews would be conducted to determine if targets met. Benefit expansion would occur only if deficit reduction target is met. ▸ Deficit reduction target would be $50-100 B over ten years (assume lower targets in early years).
	Issues: · With two different levels of benefits, adverse selection against the standard benefit package is a danger. Risk adjustment across the packages could increase the cost of the basic package (Jim is working on this).

[1] Three scenarios should be tested, with the value of the basic package 10%, 15% and 20% less than the standard package.

. Employer Payments	Firms with more than 20 employees: · Employers generally would be required to pay 80% of the average per worker premium for the basic benefit package. ▸ Employer payment for each worker would be capped at the lower of 80% of the average per worker premium or a specified percentage of the worker's wages (Scenario A schedule). ▸ Large firms (over 1000 threshold) would be eligible for subsidies based on the average per worker premium for community- rated employers in the area. Exempt firms: · Exempt employers would not be required to provide coverage. ▸ Exempt employers with fewer than 10 workers pay 1% of payroll. ▸ Exempt employers with 11 to 20 workers pay 2% of payroll. · Employers with 20 or fewer employees that choose to cover their workers are treated as above. · The exemption would be eliminated if specified percentages of the population are not covered by specified dates: ▸ 90% of currently uninsured working families must be insured by 1998; ▸ 95% of currently uninsured working families must be insured by 2000. Self-employed people: · OPTION 1. Self-employed people with employees are treated as employees of themselves and are eligible for exemption. Self-employed people without employees pay as under the HSA (e.g., self-employed with working spouses make payments that are applied to reduce federal subsidies). · OPTION 2. All self-employed people are eligible for exemption.

. Employer Payments (Continued)	Per worker premiums: The per worker premium calculation would be based on the employer contributions for the basic package; employer contributions above the amount required (including any payment toward the difference between the basic package and the standard package) would be considered to offset family payment responsibility. Firms with fewer than 20 employee that choose to provide coverage are counted in per worker premium calculation.
. Family Payments	Families working for nonexempt firms (including exempt firms that choose to provide coverage): · Families pay 20% of the average premium for the basic package. · Low-income families are capped at a percentage of income for the family share for the basic package. (Scenario A subsidies). Families working for exempt employers: · Families working for exempt employers pay the entire premium (a per worker employer share and a family share) for the basic package. · Families working for exempt employers are capped at a percentage of income for the entire premium. ▸ The cap ranges from 4-6% (Kennedy schedule for exempt workers). Nonworking families: · Nonworkers pay toward the employer share as under Scenario A. Families choosing standard package: · Families choosing the standard package are responsible for the full difference between the basic and standard packages. · No subsidies apply to the difference. Special rules for dual earners: · Families with a worker in an exempt firm and a worker in a nonexempt firm are treated as a family working for a nonexempt firm.

. Subsidies	Federal costs for subsidies are capped as under the HSA. Employers: · Employer payments for an employee for the basic plan are capped at 2.8% to 12% of the employee's wages. (The Scenario A subsidy schedule applies.) · Caps apply to all employers. For experience rated employer, payments are subsidized only up to the level of required employer contributions for the basic plan in the appropriate community rating area. Families: · Family payments for the family share of the basic plan are capped at 3.9% of income. (The Scenario A subsidy schedule applies.) · Families working for exempt employers are capped at 4–6% of income for the entire premium obligation (Kennedy schedule for exempt workers). · Payments for nonworking families for the employer share are based on nonwage income and are capped as under the Scenario A approach. · Special subsidies for cost-sharing are provided for low-income families during the benefit phase-in period. ▸ Low income families enroll in HMOs (if available). For those under poverty, the difference between the standard HMO cost-sharing and the basic HMO cost-sharing is fully subsidized. For those with incomes below 150% [200%?] of poverrty a portion of the difference would be subsidized (on a sliding scale basis). ▸ If no HMO is available, low-income families would be subsidized to the same extent in a non-HMO plan. Self-employed: · OPTION 1. Self-employed people without employees pay as under Scenario A (e.g., self-employed without employees capped at small employer schedule). · OPTION 2. All self-employed people are treated as exempt workers unless they employ more than 20 workers in their firm.

. Community rating threshold	Firms with 1000 or fewer employees are part of community rated pools. · Large firms cannot elect to be community rated. · Taft-Hartley trusts and rural electric and telephone cooperatives can elect to be experience rated. · State and local governments are community-rated employers. · All experience rated employers (including state and local governments) pay a 1% of payroll surcharge.
. Cost containment	· Constrain initial premiums (as under HSA) and growth rates as follows: ▸ OPTION 1. HSA growth rates. ▸ OPTION 2. Managed competition growth rates through 1998, HSA growth rates thereafter.

GENERAL DESCRIPTION (Continued).	**Families:** · Families working for nonexempt employers pay the difference between the 80% of the average premium for the basic package and the premium of the plan they choose. · Families working for exempt employers pay the entire premium. · Families choosing the standard package are responsible for the full difference between the two packages. · Low-income families are capped at a percentage of income for the family share for the basic package. · Families working for exempt employers are capped at percentage of income for the entire premium for the basic package. · Special subsidies toward cost-sharing are provided for low-income families during the phase-in period. **Cost Containment:** · Reverse trigger approach. **Subsidies:** · Federal subsidy costs are capped as in HSA **Community Rating:** · The threshold for community rating is reduced to firms with 1000 or fewer employees. · Firms above the threshold would pay a payroll surcharge of 1%.

PRELIMINARY DRAFT
May 16, 1994 (10:51am)

GENERAL DESCRIPTION	**Benefit Package:** · To reduce the costs of the mandate to employers in the first few years, two benefit packages, a basic package and a standard package, would be defined. The basic package would be [20%] less than the standard package. Employer payment requirements would be based on the basic package. · Over a 5-year period, if federal saving are achieved, the value of the basic package would be phased-up to the value of the standard package. ▸ Savings would be assessed annually before benefits are expanded. **Firms with more than 20 employees:** · Employers would be required to pay 80% of the average premium for the basic benefit package. · Employers payments would be capped at a specified percentage of each worker's wage. Smaller firms would receive more generous subsidies. · All firms would be eligible for subsidies. **Firms with 20 or fewer employees ("exempt employers"):** · Exempt employers would not be required to provide coverage. · Exempt employers with fewer than 10 workers pay 1% of payroll. · Exempt employers with 11 to 20 workers pay 2% of payroll. · Employers with 20 or fewer employees that choose to cover their workers pay 80% of the average premium for the basic package and are eligible for subsidies. · The exemption would be eliminated if 90% of currently uninsured workers are not insured by 1998 and 95% insured by 2000. **Tax treatment:** – Tax treatment of employer contributions is the same as in the HSA. **Maintenance of Effort:** OPTION, require employers that currently contribute more than the cost of the basic package to maintain effort (modelling should assume MOE).

Draft PRESIDENTIAL REMARKS FOR HOUSE CAUCUS *Draft*
May 25, 1994

During the last election, we told the American people that if they elected a Democratic President and a Democratic Congress, we would break the gridlock and put our government back on the side of working families. We told them, give us a chance and we will be responsive to you, responsible to you and accountable to you.

Well we have and we should be damn proud of it.

When we started our unified mission over a year ago, the deficit had been climbing for a decade, we had a stop and start, slow job growth economy and a legacy of gridlock and inaction on the very national problems that required urgent and compelling action.

Together we have charted a new course. On issue after issue we have fought off gridlock, turned back the special interest, and reversed the legacy of supply-side economics. Now the question we must ask ourselves is the same question we will ask the American people this November: do we want to go back to gridlock and supply-side, or are we willing to keep working together to move forward in realizing the values that define our party and our nation.

No one here should forget what we have accomplished together. We came in, and with no help from a single Republican, passed an economic plan that cut the deficit nearly in half. And whatever honest disagreements we have among ourselves, we should be proud that we achieved this deficit reduction in a fair way that still allowed our recovery to bloom. The plan we passed cut over 300 programs. It raised income taxes only on the top 1%, while giving 15 million working families a tax cut and making 90% of small businesses eligible for tax cuts. Indeed, we now are projected by the OECD to have the lowest deficit as a percentage of national income of any major economy in the world.

We passed the Family and Medical Leave Act, which was gridlocked for seven years, the Brady Bill, gridlocked for seven years, the crime bill gridlocked for five years, and must most recently the assault weapon ban. We are making history on trade with NAFTA, by breaking the impasse on GATT and through a new export strategy.

On issue after issue we have stood together, worked together and together acted to change America. Fifteen million families -- making up almost 50 million people with an earned income tax credit. Hundreds of thousands of children now immunized because we passed an immunization bill. Hundreds of communities are developing comprehensive blueprints for economic revival because you passed the Empowerment Zones bill. Tens of thousand of young people are touching millions of peoples' lives through National Service larger than even the best days of the Peace Corp; 100,000 police officers on the street making thousands of communities safer places to live. [Goals 2000, new school-to-work bill, more for Head Start, a full funding path for WIC program, a new defense conversion initiative called Technology Reinvestment Program, college loan reform]

Our actions will make a difference in millions of people lives. And our actions in lowering the deficit, lowering trade barriers and raising confidence in our economy is already making a difference.

In the first 15 months of this new era of Democrats governing together, our economy has one of the best record of private sector job creation in history. We've created more jobs in a little over a year than were created in the previous four years combined, and over 92% of the jobs we have created have been in the private sector. Indeed, we have created almost nine times more private sector jobs per month than were created during the previous Administration. Nearly nine times more.

And next Friday, when I'm in Europe commemorating the 50th Anniversary of D-Day, back home we are likely to mark the creation of 3 million jobs in the first third of this term -- well ahead of our goal of 8 million jobs in four years. Over half of these jobs are good, high-skill, high paid jobs. Yes, too many of the other new jobs are temporary and often without health care. Yet, that is why our work is far from done. We have to do more to create more and better jobs and to ensure that our people are equipped to prosper in the new world economy.

That is why it is so vital that we not only pass GATT but that we also pass a new re-employment act that empowers our people who do suffer dislocation to move as fast as possible to a new job, a good job with secure wages. These are top economic priorities of mine.

But we all know that the greatest thing we can do for the American people to give them security, than by passing health reform and doing it this year. I want to first congratulate you in the important work you've accomplished so far. Never in the history of this great body has the consideration of real health care reform --including universal coverage -- advanced as far as you have taken it in recent weeks, and I feel confident we have moved closer to our ultimate goal.

The progress you are making is finally answering America's call to action that has gone unheeded for too long. You in this room have fought for years to bring this issue to the fore, and now we stand poised to translate our collective best efforts into real, sustainable improvements for American health care. We have engaged in more than a year and a half of debate and discussion on this issue: from town hall meetings to the halls of the Capitol. There have been twists and turns along the way -- there are no doubt more ahead -- but we are steadily moving closer to our goal: passage of major health care reform legislation this year. What is different this time? This time there's no turning back: the American people have raised their voices and said "Do it carefully, do it right. But this time, finish the job."

Why do we need to get this done this year? Because the American people expect and demand that we do it. Because they will not -- and should not -- tolerate gridlock on an

issue that effects each and every family, each and every business, each and every doctor and hospital. And because we as Democrats have a special obligation to see this effort through.

Health security is something that defines who we are as Democrats -- it is something we stand for. Democrats have always fought for a better life for working Americans, and for a Government that encourages work as the means to personal security. Our health care plan is based on this simple, democratic idea. If 9 out of 10 people with private insurance get it in the workplace, and eight out of ten people without health insurance have somebody in their family that works, and you want the system to be as private as possible, wouldn't the best thing be to say that everyone is guaranteed coverage through the workplace, and that small businesses and low income families get special help to make insurance affordable? Shouldn't everyone take some responsibility to make things as fair and affordable as possible?

I continue to believe that we have a responsibility as lawmakers to work together without regard to party and bring security to American families. I continue to hope that this body will fashion a bi-partisan solution to the health care crisis. But I also want to reiterate what I said in my State of the Union address: I will not sign any bill that does not guarantee private health insurance to every American. I know there are those who say let's not stand so firm on this, let's accept universal access in the place of universal coverage. Or let's just start with some insurance reforms and come back at this next year. We shouldn't do that, and we can't afford to do that. We will never get the deficit under control, never get health care inflation under control, and never provide true security to hardworking American families until we impose some order on this system, and bring everyone into it.

I got a letter last week from a little boy from my home state of Arkansas who has asthma but has no insurance. He told me we'd brought his family hope; now we have to bring them help. He's right. I look forward to working closely with you throughout the summer to hammer out a plan that is acceptable to all of us in this room, and hopefully some of your colleagues from the other side of the aisle. I'm confident that working together, we can bring this little boy's families, and the other families who are counting on us, the help and security they deserve.

U.S. SMALL BUSINESS ADMINISTRATION
OFFICE OF THE ADMINISTRATOR
409 THIRD STREET, S.W.
WASHINGTON, D.C. 20416

FAX MESSAGE

DATE: 5/27 — 5 PAGES + COVER

TO: Chris Jennings — FAX#: (202) 456 7431
WHITE HOUSE — PHONE#: (202) 456-____

FROM: Susan Ohrin — FAX#: (202) 205-6802
PHONE#: (202) 205-~~6695~~ 6812

SUBJECT: Chris - would you mind

MESSAGE: giving this your stamp of approval. Erskine wants to make sure this is OK w you guys.

Susan!
This is fine w/ Ira & me. Go w/ it unless you have to go through OMB too...
See you. Happy Memorial Day

PAUL D. COVERDELL
GEORGIA

United States Senate

WASHINGTON, DC 20510-1004

May 16, 1994

The Honorable Erskine B. Bowles
Administrator
Small Business Administration
409 Third Street, S.W.
Washington, D.C. 20416

Dear Erskine:

As the debate on health care evolves, I am becoming concerned with the noticeable disconnection between the business community and the Small Business Administration (SBA) on the issue of healthcare. While the Chamber of Commerce, the National Federation of Independent Businesses (NFIB), and several national surveys have indicated that the business community is overwhelmingly opposed to the Clinton Health Security Act, the SBA continues to promote the Clinton plan as benefitting small businesses. I believe this confusion needs to be addressed.

Small businesses are concerned that the Clinton plan, if passed, will impose an employer mandate on small businesses, forcing many of them to close their doors or lay off employees. The business community indicates that this mandate will result in the loss of at least 850,000 jobs in the first full year of implementation. How can the SBA advocate such a devastating mandate?

Secondly, if this bill will have such a severe adverse effect on the economy, I must question how the measure can benefit business. I would appreciate your thoughts on this long term dilemma.

Finally, I would like to receive any material the SBA is using to explain or endorse the Clinton health care bill. As a member of the Senate Small Business Committee, I am particularly concerned with the mission of the SBA and would like to review this material before the Senate considers the FY 1995 appropriations.

Your prompt consideration of this request is greatly appreciated.

Sincerely,

Paul D. Coverdell
United States Senator

PDC/jlp

The Honorable Paul Coverdell
United States Senate
204 Russell Building
Washington, DC 20510

Dear Senator Coverdell:

Many thanks for your letter concerning the debate on health care. I agree with you that there is probably no more important issue facing the small business community than health care. Everywhere I have gone, it is the first question that our small business customers ask us, and there is little wonder why.

Today, small businesses are experiencing annual increases in the cost of health care of 20% to 50% per year. Small businesses today pay 35% more for the same health care coverage that big businesses pay. And small businesses are not only experiencing these skyrocketing increases in the cost of health care, but unfortunately the only coverage that many small businesses can afford today is pretty poor. Many small businesses today can only afford to buy "bare bones" coverage or coverage that has such a huge deductible that it only covers catastrophic events.

Beyond this point, it is not only the skyrocketing increases in the cost of health care and the poor coverage that small businesses are able to buy today, small businesses are also uniquely subjected to every abuse in the health care system -- everything from occupation redlining to exclusions for pre-existing conditions.

In addition, the playing field for small businesses isn't level. Small businesses don't have a benefits department, so we don't have anyone to negotiate with the insurance companies on our behalf. We are thousands of inefficient buyers out there, trying to negotiate with the big insurance companies. And since we don't have a benefits department, we have to take time away from our valued customers and from managing our businesses just to try to negotiate some kind of reasonable price for health care coverage.

In addition, today if you are self-employed, you are only eligible for a 25% deduction for health care costs, whereas everyone else is eligible for 100%. That's not fair.

Beyond that point, small businesses are experiencing extraordinary increases in the cost of workers' compensation insurance. The primary culprit here is the medical cost of workers' compensation, which is growing at an extraordinary rate.

Based on the above, I think you would agree that there is every reason for small business to be concerned about health care.

Your letter indicates that you believe that the President's plan will result in the loss of at least 850,000 jobs in the first full year of implementation. You also state that the bill will have a severely adverse effect on the economy. Other experts simply don't agree with your assessment.

As the CBO concluded in its report, the Clinton plan would not significantly slow the economy or result in the loss of jobs. The CBO says that the President's plan would benefit smaller firms that typically pay much higher premiums than larger firms. It goes on to say that this levelling of cost will benefit all small businesses, not just those that provide insurance today. In addition, a study from the Economic Policy Institute predicts that the plan will create more than 358,000 manufacturing jobs over the next decade and the Employee Benefit Research Institute predicts that the President's proposal could create as many as 660,000 jobs overall.

In point of fact, in Hawaii, where they have had an employer mandate since 1974, the unemployment rate has dropped to one of the lowest in the nation, small business creation has remained high, and, most importantly, the rainy day fund that was set up to help the smallest businesses provide insurance has only been tapped five times in this entire nineteen year period. And finally, while Hawaii ranks near the top of the states in the cost of living, its average health insurance premium is near the bottom.

In your letter, you also ask for me to send you any material that SBA is using to explain or endorse the Clinton health care plan. The only information that I know of that we are currently using is a worksheet which allows businesses to calculate what their costs would be under the Clinton health care plan, compared to what their costs are now. This information was previously sent to your office and I believe I received a "thank you" letter from you for sending such. I am enclosing a copy of this worksheet with this letter.

I appreciate your letter and look forward to talking with you in the days ahead. With every best wish,

Sincerely,

Erskine B. Bowles
Administrator

Enclosure

205-6802

STATEMENT OF THE PROBLEM

♦ In a system based on voluntary purchase of insurance along with guaranteed issue, it is possible that the risk pool of insured will deteriorate: that the healthy will be more likely than they are today to be uninsured, and that premiums for those who are insured will increase. This would be undesirable and we would want to protect against this scenario.

IS IT LIKELY THAT THE MANY OF THE HEALTHY WILL DROP INSURANCE?
(answer: It depends on what assumptions one makes about employer maintenance of effort.)

♦ **If the subsidy schedule and tax treatment is such that it is reasonable to assume that most current employer effort will be maintained, then significant deterioration of the risk pool over a three to five year time period is probably not a serious concern.** The current non-group market is relatively small (approximately 7% of the under-65 population). Some of those who purchase non-group coverage might drop it as a result of movement towards community rating and guaranteed issue. However, if the community rating pool is broad -- e.g., community rating up to 1,000 (or even 100) -- the effects on the overall composition of the risk pool should be relatively small.[1]

♦ However, if the subsidies are generous enough that significant numbers of employers would be expected to drop coverage, provide a wage increase, and allow their employees to choose whether or not to purchase insurance, then the numbers of people potentially purchasing in the non-group market would increase. In this scenario, we might expect the pool of insured persons to deteriorate over time as the healthy chose to exit.

HOW COULD WE MEASURE WHETHER THE RISK POOL OF INSURED IS DETERIORATING?

♦ If the average age of insured persons is increasing, then we could assume deterioration in the risk pool. Assuming we had some data system which indicated whether or not each individual (or a sample of people) are insured, we could measure whether the average age of insured persons increases during the pre-trigger time

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[1] From the vantage point of individuals, 'relatively small' might mean a premium increase of 2%-5% (e.g.). That is, premium increases of this order of magnitude would be hard for the individual to distinguish from background noise. However, in later discussions on how premium caps could be implemented in a system with voluntary enrollment, fluctuations of this order of magnitude would be relevant and would require adjustments in the premium cap formula.

period. A similar data system will be required in order to determine whether or not to 'pull the trigger'.

- Average age is an extremely weak proxy for measuring the deterioration of the risk pool. With the appropriate age rating, there might be no change in average age among the insured, but it could still be the case that the relatively healthy (at any given age) are exiting the pool of the insured.

- However, there are probably no other good choices for obtaining reliable and timely measurement of whether the risk pool is deteriorating.[2]

IF THE RISK POOL IS DETERIORATING, WHAT POLICY RESPONSES ARE POSSIBLE?

♦ If we find that the pool of insured persons is aging, then we would want to protect the insured against the increased premiums that would result.

♦ We could provide this protection, in theory, by providing an outside funding source which would allow health plans to reduce the premiums they charge to the insured. For exmaple, to the extent we determined that deterioration of the risk pool was raising premiums for the insured, we might assess employers not providing health insurance.

♦ This money could be used to 'buy down' premiums for the insured. The simples method would be to make a per capita payment to all health plans for each person insured; this would reduce premiums to the insured to compensate for a deteriorating risk pool. Alternatively, the outside funding source could be used to provide reinsurance for very high cost cases -- e.g., for the 1.6% of households with

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[2] Assuming we could get the data, we could examine the percent of insured persons with expense above some level -- e.g., $10,000 or $30,000. Then if the percentage of the insured with high expenditures increases from year to year, we could assume that the risk pool deteriorated. However, there would be a number of complications with such an approach. From NMES data, 8.1% of the under-65 health insurance units have expenditures over $10,000 per year. If the healthiest 5% of the currently insured chooses not purchase insurance, the 8.1% would increase to 8.5%. Differentiating an increase of this magnitude from the background effects of general medical care inflation, measurement error, white noise, and changed incentives for reporting would be extremely difficult (and even worse if we were trying to do this at a state-by-state level). Alternatively, we could add some questions to the CPS on self-reported health status to attempt to track deterioration in the risk pool of the insured. While this might give us some indication of the direction of change, it would not be sufficient to allow measurement of the effect of any such changes on average premium.

expenditures above $30,000 per year that account for 20.3% of expenditures.

♦ This outside funding source could be raised, for example, by an assessment on those employers who do not provide health insurance. As the number of people insured increased, both the need for the assessment and the revenue from it would decline in tandem.

♦ **It is not likely, however, that we will be able to do a good job of measuring the extent to which the risk pool is deteriorating or the effect of such changes on the average premium paid by the insured.**

MANDATORY REINSURANCE FOR HIGH COST CASES

♦ The HSA specifies that prospective and retrospective 'risk adjustment' should be used to assure that plans with a disproportionate number of high cost cases should not be disadvantaged as a result.

♦ A risk adjustment system, including, potentially, retrospective reinsurance for high cost cases, would be required in a system without universal coverage as well. In fact, the stress placed on the risk adjustment system will be greater when people are choosing whether or not to be insured than in a system of mandatory insurance.

♦ However, a reinsurance system for high cost cases is neither necessary nor sufficient to deal with the potential problem of deterioration of the risk pool. If the healthy exit the insurance system, the premiums for the remaining insured will increase. Providing reinsurance for high cost cases (funded by an outside source) will protect against part of the effect on premium, but most of the effect will not be accounted for by such a mechanism.[3]

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[3] If the healthy exit the insurance market, the insured will have a higher proportion of 'high cost cases' than previously. A reinsurance mechanism could protect against the effect of this on premiums. However, there will also be a higher proportion of 'fairly high cost cases', and of 'somewhat high cost cases'; we have no good way of protecting against these effects. Unless we are thinking of reinsuring more than 20% of expenditures, at least 80% of the effect of a deteriorating risk pool would not be compensated for by a reinsurance mechanism.

SUMMARY

♦ If the structure of subsidies and the tax treatment of employer provided and individually purchased insurance is such that it is reasonable to assume that most employers will maintain effort, then we do not need to worry much about deterioration of the risk pool and its effects on premiums paid by the insured.

♦ If significant numbers of employers are likely to drop effort, then deterioration of the risk pool may be a problem. However, in this case we are unlikely to be able to do a good job of either measuring the magnitude of the effect, or of adjusting for it.

♦ Setting up a national reinsurance mechanism for high cost cases will not resolve the major problems that would be created if the risk pool does deteriorate.

♦ When considering how to implement premium caps in a system with voluntary enrollment, careful attention must be paid to the effects of changes in the composition of the risk pool on the level of premium increase that should be allowed.

AUDIENCE

MESSAG

	Sun	Monday	Tuesday	Wednesday	Thursday	Friday	Sat
M	15	16 WORKPLACE EVENTS →	17 →	18	19 MRS. GORE PRESS RT	20	21
A	22	23 RECESS PREP →	24	25	26	27	28
Y	29	30	31 ED BRD. MAILING	1	2 ICKES / IRA PRESS RT.	3	4
J	5	6 VP PRESS RT.	7 COST CTRL. EVTS →	8	9	10	11
U	12	13	14	15	16	17 END WORKPLACE	18
N	19	20 QUAL/CHOICE EVTS →	21 NBC SPECIAL	22	23	24 END COST CTRL.	25
E	26	27 FIREBOATS?	28	29 RECESS PREP →	30	1 END CHOICE/QUAL	2
J	3	4	5 ED. BRDS. →	6 BRIEFING SERIES →	7	8 ED BRD MAILING →	9
U	10	11	12	13	14	15	16
L	17	18	19 DEFIN. SPEECH	20	21 BUS TOURS →	22 END BRIEFINGS	23
Y	24	25	26 DISABLED RALLY	27	28	29	30
	31	1	2	3	4	5	6
A	7	8 RECESS PREP →	9	10 END BUSES	11	12	13
U	14	15 WALK THRUS →	16	17	18	19	20
G	21	22	23	24	25	26 END WALKTHRUS	27
	28	29 ED BRDS. →	30	31	1	2	3
S	4	5 RALLY SERIES →	6	7	8	9	10
E	11	12	13	14	15	16 END RALLIES	17
P	18	19	20	21	22	23	24
T	25	26	27 DC RALLY	28	29	30	1
	2	3	4	5	6	7 SINE DIE	8
O	9	10 VICTORY LAP →	11	12	13	14	15
C	16	17	18	19	20	21	22
T	23	24	25	26	27	28	29
	30	31	1	2	3	4	5
N	6	7	8 ELECTION				

WASH. + COMMITTEE TARGETS (PAID)

OPINION LDRS. (FREE)

NAT'L (PAID + FREE)

FLOOR TARGETS (FREE)

FLOOR (PAID) + NAT'L (FREE)

DEFEND PRINCIPLE + SHOW PROGRE

DEFINE 'NEW' BILL

URGENC + CRISI

REASSU + DEFIN SUCCES

URGENC

HISTORIC MAGNITU

6/1/94

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE ASSISTANT SECRETARY FOR LEGISLATION
HEALTH LEGISLATION
WASHINGTON, D.C. 20201

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PASSAGE OF MEDICARE 1965

H.R. 6675 passed House Ways and Means Committee on March 29, 1965 Vote 11 - 8;

- All Democrats supporting and all Republicans (Battin, Betts, Broyhill, Byrnes, Collier, Curtis, Schneebeli, and Utt) opposing.

On floor, bill passed by a vote of 313-115;

- One Republican changed his vote - Schneebeli.

Conference Report #682 filed July 26, 1965; floor action July 27, 1965; Rollcall vote 203 - yeas 307; nays 116; not voting 11.

- On the final passage, 3 Republicans from Ways and Means voted yea - Broyhill, Byrnes, and Schneebeli.

H.R. 6675 passed the Senate Finance Committee on June 30, 1965; We have not been able to get the Committee vote however, we do know that the Committee composition was 11 D / 6 R (Bennett, Carlson, Curtis, Morton, Dirksen, Williams);

On floor, bill passed by vote of 68-21; 11 not voting.

- One Republican voted yea - Carlson; in addition, Dirksen did not vote.

On passage of the Conference Report floor action July 28, 1965; Rollcall vote 201 - yeas 70; nays 24; not voting 6.

- There were no cross over votes from the prior floor passage, however, Curtis and Dirksen did not vote.

Date of enactment July 30, 1965; P.L. 89-97.

PASSAGE OF SOCIAL SECURITY 1935

H.R. 7260 passed House Ways and Means Committee on April 5, 1935 (House report #615) without amendment. The bill was passed on a partyline vote of 17-7

Passed House on April 19, 1935

- Roll call vote #57; 372 yeas; 33 nays; 2 present; 25 not voting. Five of the seven Ways and Means Republicans switched their votes and supported the passage of the bill. One maintained his nay vote; and one member voted present.

Conference report final action August 8, 1935 by voice

H.R. 7260 passed Senate Finance Committee, May 13, 1935 (Senate report #628)

- The Archives does not have the minutes from the Finance Committee therefore, we are unable to obtain the vote breakdown.

Passed the Senate on June 15, 1935 by a vote of 77 yeas; 6 nays; 12 not voting.

- Since the Committee vote is unavailable we don't know if there were any vote changes.

Conference report August 12, 1935; voice

Date of enactment August 14, 1935; P.L. 74-271.

LEON E. PANETTA
DIRECTOR
OFFICE OF MANAGEMENT AND BUDGET
SPEECH TO THE CENTER FOR NATIONAL POLICY
JUNE 20, 1994 **DRAFT -- 6/18**

UNDERLINED PARTS ARE NEW

I want to thank the Center for National Policy for providing me with this opportunity to speak to you today. The Center for National Policy has been an important focal point for debate on a broad spectrum of issues affecting our nation. You have made important contributions to these issues and have directly affected the course not only of debates but of decisions and actions.

It is therefore appropriate that we discuss today an issue that will certainly affect every citizen and taxpayer in this country -- health care reform. Today, I want to talk to you about health reform and focus not so much on the delivery of health care but rather on what the President believes, and what I believe, is an absolutely essential element of reform, and that is controlling the skyrocketing costs of our health care system.

The President was elected in 1992 on his promise to focus on fundamental changes in the nation's economy, in our government, and in the lives of America's families. That he has done. Working with the Congress, he has put in place an economic plan that has reduced budget deficits and increased investment in long-term economic growth and in the education, skills, and well-being of our workers and our children. He has implemented a trade policy that is already increasing exports and creating new opportunities and jobs throughout this country. He has signed into law the Family Leave Act, Goals 2000 education reforms, a historic national service program, and reforms in Head Start and other

education programs. Last week, the President proposed a strong, measured reform plan to turn the nation's outdated and, in so many ways, counterproductive welfare system into a plan for work and responsibility.

Fundamentally tied to all of these changes in government, in the economy, in the well-being of our families is the need to reform our health care system. There is a clear consensus that the nation cannot sustain the inadequacies, the bureaucracy, the waste, or the costs of the present system. Reform is essential to continuing deficit reduction, it is essential to our efforts to restore America's economic strength, and it is essential to the security, to the well-being, of every American family.

As health care has been debated in the Congress and in the press, one of the issues that has aroused controversy is whether to effectively control health care costs, a key goal of the President's legislation.

Without real cost control, health costs will continue to consume an ever-growing share of household, business, and government budgets, robbing national income that we need to save and invest now for a better future.

Some argue that we should just rely on the word of those in the health care system to hold down costs. But as one observer has written, the health care system has become overbuilt, overused, and overpriced. How can we provide affordable health care for all Americans and not deal directly with costs? The answer is, we cannot.

The United States devotes the highest proportion of GDP to health care of any industrialized country -- 14 percent -- yet insures the smallest percentage of its citizens. If current trends continue, by the end of the decade 14 percent will rise to 18 percent, yet some

38 million Americans will still have no health coverage. And government, businesses, and families, will continue to face rapidly rising costs, with no end in sight.

How can we not control costs? How can we not? The American people want real health care reform. But does anyone seriously think that they want the Congress to go through this process and end up not controlling costs? The reality is, the stakes in constraining national health spending are huge -- for families, for businesses, and for government.

First, government. And for government, read the taxpayers, all of us. Last year, Congress and the President reversed the trend of rising budget deficits by making some very tough choices about spending and taxes. Even so, the reality is that without comprehensive health reform, deficits will rise again in the latter part of this decade. Why? Because there is one remaining area of the Federal budget that is out of control. It's not defense spending, and it's not foreign aid, and, if you leave out health, it's not social spending. It is health care. The Congressional Budget Office projects that without reform, they will rise by over ten percent for ten consecutive years -- obviously well beyond the rate of overall inflation.

If you consider all of the spending increases expected over the next several years, 90 percent come in three areas. Third is interest on the debt. Second is Social Security, largely because of a growing senior population, although the Social Security trust fund continues to run a substantial surplus. In first place, and easily leading the pack, is health costs, which make up more than 50 percent of anticipated spending increases.

Of course, if deficits could keep up with that spending, then deficits would not grow, but even in a strong, growing economy, revenues simply will not keep up with the pace of health spending.

So controlling health costs is absolutely essential to maintaining the path of deficit reduction.

It is equally essential to the nation's economy. Businesses face the same problem as government -- skyrocketing costs which take a greater share of profits and payroll, which force many to limit the insurance they provide their workers, and prevent all to many, as we know, from providing it at all.

Perhaps the best known is example is the automobile industry. Health costs for the Big Three automobile manufacturers average over $1,000 per car, placing them at a massive disadvantage to Japanese carmakers. Every product we manufacture, every service we provide, contains a growing health care tax premium. And that is true regardless of the size of the business. Small businesses today are charged an average of 35 percent more than large businesses for the same insurance. Whether large or small, businesses desperately need predictable, affordable health costs.

And finally, families, particularly middle-class families, are finding it more and more difficult to ensure that they have adequate health care. First, just like government and businesses, they are facing rising costs for insurance, for doctors' visits, for prescription drugs. In addition, though, efforts to control costs in today's marketplace result in families being denied insurance just when they need it most -- because of a serious illness or other long-term condition.

So families today live with the knowledge that they are one serious illness or one job change away from losing their health insurance. And because protecting families is at the core of health care reform, one of the fundamental ways in which we need to protect them is not only to guarantee coverage but to control skyrocketing costs.

If someone had sought to design the highest-cost system possible, they would have come up with our current system. There are few incentives today to control spending: the consumer bears only a fraction of costs; patients do not have the information they need to make meaningful choices; and most consumers must pay whatever providers charge. We need to change that market fundamentally. We need to create real competitive pressures and then guarantee them with cost constraints.

Our primary strategy for cost containment is private sector competition -- creating the right economic incentives to provide choices, bring costs in line, and encourage health plans to compete on price and quality. This will slow down costs, but we also need to build some discipline and certainty into our system. It would be irresponsible not to back up health security with cost security.

Indeed, what seems to get lost in the debate over specific cost-containment mechanisms is that we need to design a system that is inherently more cost conscious than the one we have today. We can debate forever about which specific cost containment mechanisms to use, but the fact is that most consumers, providers, and insurers do not now have adequate incentives to spend our health care dollars wisely -- and that is one market failure that health reform must correct.

The President's plan gives most consumers more choice of plans than they have in today's system, where so many employers offer only one plan. And consumers will be provided with information about the plans from which they are choosing, in a form they can use to compare health plans -- which most people don't have today. Plans will provide a standard benefits package, so the system will allow consumers to make an apples-to-apples

comparison based on price, on quality of care, on previous customer satisfaction, on experience.

And because the plan stresses responsibility by requiring consumers to pay a portion of their premiums, they will have a financial stake in choosing the lowest cost plan that meets their individual needs. And they will be given an annual opportunity to switch plans if their plan does not live up to their expectations.

The plan also strengthens competition in health care by requiring providers and insurers to provide care to all who seek coverage, and to provide that care within a set premium. A key element of that is the choice of plans provided to consumers. Choice is essential to competition. To be competitive in the reformed health marketplace, providers will have to consider the cost-effectiveness of the care they give. And insurers will need to take a more active interest in monitoring the cost and quality of the care they are asked to pay for. This is how the President's plan uses the instruments of competition to squeeze excess costs out of the system.

These policies are the building blocks of incentive-based cost containment in a reformed health care system. But we need to build accountability into the system as well. So, In addition to encouraging real competition, the President's plan uses three additional protections to control costs: short-term protection in the first year of reform; long-term protections; and protections to control budget deficits.

Setting an accurate premium level in the first year is a critical step towards real cost containment. Today, millions of uninsured individuals cannot pay when they use the health care system. Doctors and hospitals set their fees -- and insurers set their premiums -- about

25% higher for those who do pay to cover these uncompensated costs. That, of course, is one of the fundamental arguments in favor of universal coverage.

With universal coverage, all Americans would be insured, so there would be virtually no uncompensated costs. Therefore, we need to set an appropriate premium ceiling in the first year of health reform; otherwise, the health industry will reap a huge windfall because they will effectively be paid twice for the uninsured -- once when the uninsured get insurance and pay their premiums and again when everyone else still gets charged more. This windfall, worth hundreds of billions of dollars to insurance companies over the next several years, would come straight out of our pockets.

The costs of the system are high enough. The health industry should not be permitted to collect fees and premiums twice for the same care. To prevent that, setting an appropriate first-year premium is essential.

To provide the long-term protection that American businesses and families demand, the President's plan ties the future growth in health insurance premiums to a reasonable scale of increases.

This protection makes sense. Limits on premium increases are preferable to direct Federal micro-management of health care costs -- for example, through a system of Federal price controls for specific procedures. The Federal government should not set prices for all of the tens of thousands of private health transactions that take place every day. The President rejected that approach in favor of broad limits on the rate at which insurance companies may raise premiums. The President's plan leaves it to those who know the system best -- health plans, doctors, and nurses -- to eliminate waste while improving the quality of care.

We believe that by reforming the way the health care market works -- permitting providers to compete efficiently and giving consumers the information they need to make prudent and cost-effective choices -- health care cost increases will be slowed. But if competition does not hold premium growth within reasonable targets, then premium caps will be triggered.

Some argue that these limits are too stringent to maintain the high quality of care that Americans receive today. This is simply untrue. First, the ceilings allow for regional variations and demographic shifts. But more fundamentally, in 2004, even with these limits, the U.S. health industry would have revenues of $2.1 trillion. The average annual growth in national health spending between 1996 and 2004 would be 7.3 percent per year instead of 8.4 percent as now projected -- an important achievement but one that would more than allow the health sector to continue the high-quality care and medical advances which are the hallmark of our system.

Finally, the President's plan assists small businesses and low-income families and individuals in paying their share of the cost of insurance. However, the President rejected the notion of creating another runaway entitlement program. Therefore, the plan sets a cap on total discounts. If costs rise beyond that level, Congress and the Administration must revisit the program and fix the problem.

We are all too familiar with the problem of exploding entitlement programs, established without limits and coming back to haunt Congresses and Administrations. The cap on aggregate subsidies is a backstop that we do not expect to use. But just as we are asking the private sector to control its health costs, we are also requiring the Federal

government to be held to a measurable standard of cost containment, and we are protecting the taxpayer as well as our commitment to deficit reduction.

Regardless of the means, we need to put an end to the fantasy that we can reform the nation's health system and provide coverage to every American without containing health costs. And conversely, we cannot hope to contain costs without universal coverage. The two are inextricably linked. All the experts agree that until all Americans are insured, billions of dollars will continue to be shifted onto those with insurance coverage. And without an approach requiring universal coverage, as CBO points out, it is the middle class -- not the poor -- who largely end up without insurance.

Likewise, without cost containment, middle class families will bear the largest burden of skyrocketing costs.

Let me point out just how bizarre the debate over cost containment has become. When the Administration said that health care spending would rise to 19 percent of GDP by 2004 without reform, everyone agreed with us that 19 percent was too high and that it would crowd out important investments in the economy. But when the Administration produced a plan to reduce health's share of GDP to 17 percent by 2004, some claimed we were leading the country down the road to rationing -- even though all of our industrial competitors spend less than 10 percent of their output on health today.

If 10 percent is enough for other industrialized nations to provide universal health coverage, why should 17 percent and another $1 trillion-plus in health industry revenues mean rationing here? And if the uninsured are now receiving care -- even if it is expensive care -- why should giving them health coverage, much of which would prevent disease, drive

costs higher than they are today? The Administration should not have to defend 17 percent. It is opponents of cost containment who have some explaining to do.

If we enact health care reform that does not provide for universal coverage and control costs -- whether through the mechanisms proposed by the Administration or by some other means -- this effort will have failed.

This is a debate that is taking place not only in the committee rooms and the chambers of the Congress but in newspapers, in meeting halls, and over kitchen tables throughout our country. For 16 years, I served as a member of Congress. And for 16 years, the health care issue became a bigger and bigger problem. It was ignored until it became a crisis, as costs for families, businesses, and government spiraled out of control, as the number of uninsured Americans grew, and as more and more families came to fear the loss of their insurance coverage.

We saw a lot of suggestions, a lot of ideas, a lot of concepts proposed. We tried. But we failed. The truth is, until this President, nobody presented the kind of specific, comprehensive, responsible, detailed, paid-for plan that the Congress has been considering.

As this great national debate has proceeded, we have been challenged on policy, as we expected, and there has been a strenuous and far-reaching discussion of how best to achieve the goal of comprehensive health care reform. The Administration does not pretend to possess divine wisdom on this issue. We have welcomed alternative proposals and views.

But as the legislative process moves forward, let's make one thing clear. Let's be sure that as the various plans are considered, they meet the tests that we have sought to meet -- universal coverage, choice, cost containment. And let's try -- to the extent possible -- to be sure that the debate proceeds on the substance, not the politics and not the personalities.

The American people deserve that kind of debate because this is an issue that will directly affect every one of them every day of their lives.

As you know, the legislative process is well under way. House and Senate Committees are hard at work on their versions of health care reform. Cost containment is a critical element of their deliberations. We all know that the legislative process is sometimes not very pretty. We are in for a roller coaster ride with even steeper twists and turns than last year with the enactment of the President's economic plan.

In the end, I am convinced that Congress will pass a plan that guarantees coverage for every American and that controls health costs. And that is absolutely essential to the future of our economy and our country.

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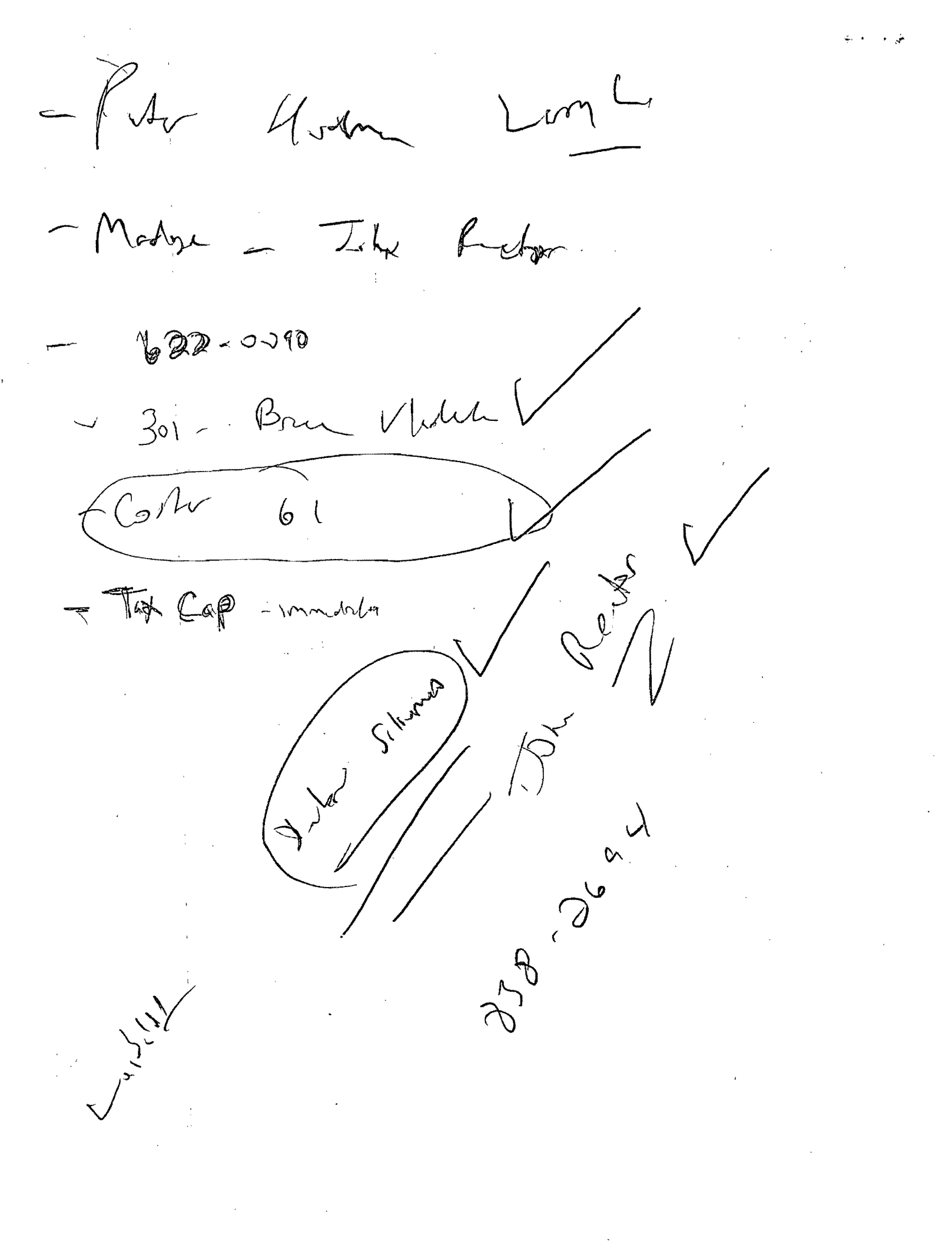

TO: Chris Jennings

FROM: David Nexon

DATE: 6/5/94

SUBJECT: Data items we need (all for Chairman's mark), per our earlier conversation

1) Estimates of overall impact of Chairman's mark on business by size of firm, divided between those currently providing and not providing coverage.

2) Estimates including 5,000 plus firms and payroll contribution for small exempt and large firms over 1,000 (earlier estimates did not include 5,000 plus firms and appeared to be for premiums only).

3) Five year and year 2000 figures for the components of Title IX: Employer premium payments, household premium payments, Federal subsidy payments (we have five year, but not year 2000); Federal payments for cash recipients; state payments, including moe and cash recipients. For employers, households, and states, we would like to be able to compare to baseline payments.

4) Is tobacco tax number ($32 billion) a 96-2000 figure or a 95-2000 figure. If the former, what is the 95-2000 figure?

5) Budget impact of various cost-containment scenarios provided to Ken.

6) Difference between average premiums of 1,000 plus firms and all people in community-rated pool. How does what the 1000 plus firms would pay if they were paying community-rated premiums relate to the one per cent assessment?

Erica/Jane:

Can you help me out w/ these relative to your Kennedy runs?

TO: CHRIS JENNINGS

FROM: ANTHONY TASSI

DATE: 06/06/94

SUBJ: Additional Data Items Needed for Chairman's Mark

After talking it over with David, it turns out we need a couple of additional items:

1) The breakout of the revenue from the 2% assessment and 1% assessment

2) The number of firms and workers for each subsidy payroll cap (ie, how many workers are in firms paying 5.5% and how many firms are there)

3) For the Bingaman Option, the number of firms, workers in the exemption -- and revenue broken down for the 1% and 2% assessment of the exempt firms.

Much thanks -- you can fax the info to me (224-3533) or telephone if you prefer (224-6366; -6064; - 5406 david's line)

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To CHRIS J.	From ANTHONY/DAVID SON
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