Withdrawal/Redaction Sheet
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo w/attach	Chris Jennings to Hillary Clinton Re: Kassebaum/Glickman "Basicare" Meeting (12 pages)	5/18/93	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Health Security Act)
OA/Box Number: 8990

FOLDER TITLE:
[HSA] Congressman Glickman (KA)

gf134

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advise between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

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cc: PAM

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DEMOCRATIC STEERING AND POLICY

ASSISTANT MAJORITY WHIP

April 20, 1993

Hillary Rodham Clinton
The White House
1600 Pennsylvania Avenue
Washington, D.C. 20500

Dear Mrs. Clinton:

Given the recent stalemate in the Senate over the President's economic stimulus package, I believe it has become readily apparent that we need bipartisan support if we want to pass any health care reform bill during this Congress. With this is mind, I want again to bring to your attention proposed legislation, which I and many of my colleagues, in both the House and Senate and on both sides of the aisle, believe could be the blueprint in establishing a foundation for our future health care system. The BASICARE HEALTH ACCESS AND COST CONTROL ACT (H.R. 834) is unique because it is the only national health care reform bill which enjoys bipartisan support in the House and Senate. Senator Nancy Kassebaum and I are the primary sponsors in our respective bodies.

Recent newspaper reports indicate that the President's Task Force is considering a managed competition bill which would include some form of cost containment mechanism. It has been suggested that this mechanism might take the form of a limit on insurance premium increases. Furthermore, I understand that the reform proposal may also include a requirement that all individuals buy health insurance. While a number of bills have been proposed which include some of these options, there are far too few viable options which combine all of these elements. Our bill, on the other hand, includes mechanisms to implement these provisions.

The BASICARE HEALTH ACCESS AND COST CONTROL ACT is not only compatible with the concept of managed competition, it has tackled many of the problems which the task force is now facing. BASICARE:

* Simplifies the private health insurance market around a single, uniform BASICARE benefit package.

* Requires all private insurers to sell the BASICARE package and requires all Americans to carry it. This provision not only avoids employer mandates but, also, minimizes adverse selection.

* Subjects individual BASICARE plans to insurance market reforms in an attempt to protect the consumer.

At the same time, this bill has a binding cost control mechanism which is simpler, less regulatory, and less unwieldy than price controls. A National Health Commission would establish a base premium rate insurers could charge for the BASICARE plan. The Commission would then set annual limits on premium rate increases. This price cap, combined with insurance market reform, puts the emphasis on efficiency and cost effectiveness rather than risk selection. It will be in carriers' and providers' best interest to form managed care networks and to compete for consumers within the private insurance market. The beauty of this approach is that it provides binding cost control with a minimum of government regulatory interference in the health care marketplace.

I look forward to having the privilege of rescheduling our meeting. Senator Kassebaum, Congressman McCurdy, Senator Danforth, and Senator Burns and I are ready to meet with you at your earliest convenience. This BASICARE group was scheduled to meet with you previously; unfortunately, due to key votes on the President's economic stimulus package, our original meeting had to be postponed.

I realize as the deadline for proposing the President's bill approaches the demands on your time must be tremendous; however, the need for bipartisanship on this issue is so profound that I urge you to meet with us before any final decisions are made. I have enclosed a copy of the bill, a brief summary, and a detailed outline of the BASICARE bill. I would be happy to provide any additional information you might require.

Again, we hope the administration will give this bill serious consideration as we all work <u>together</u> to find a solution to our nation's health care crisis.

With best regards,

Dan

DAN GLICKMAN
Member of Congress

DG:wlo

OFFICE OF CONGRESSMAN DAN GLICKMAN

Chris,

Per our phone conversation on Wed. 2/17. Here are copies of the material Mr. Glickman wants Mrs. Clinton to see. Enclosed are a letter to her, a copy of the bill, a brief summary and a detailed outline. Mr. Glickman or I would be more than happy to discuss this bill and its approach with you. Thanks again for your help and interest. Let me know if you need any additional information.

Mary Frasché

MARY FRASCHÉ
LEGISLATIVE ASSISTANT

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CONGRESS OF THE UNITED STATES

HOUSE OF REPRESENTATIVES

WASHINGTON, DC 20515-1604

February 16, 1993

Hillary Rodham Clinton
The White House
1600 Pennsylvania Avenue
Washington, D.C. 20500

Dear Mrs. Clinton:

Given your new responsibilities as head of the task force in the search for a solution to our nation's health care crisis, I want to bring to your attention proposed legislation, which I believe could be the blue print in establishing a foundation for our future system. This bill is unique because it is the only national health care reform bill which enjoys bipartisan support in the House and Senate. Senator Nancy Kassebaum and I are the primary sponsors in our respective bodies.

President Clinton has indicated his support for an approach to health care reform which combines market-oriented managed competition, global budgeting, and some type of universal mandate. The problem is that while there are advocates of pure forms of managed competition and global budgeting, there are not enough viable options to combine the two.

The key is to develop a plan with as little government regulation as possible but with adequate measures to control cost inflation. My BASICARE HEALTH ACCESS AND COST CONTROL ACT, is compatible with the managed competition concept:

* It simplifies the private health insurance market around a single, uniform BASICARE benefit package.

* All private insurers would be required to sell the BASICARE package and all Americans would have to carry it.

* Individual BASICARE plans would be subject to insurance market reforms to protect beneficiaries.

The system would be located entirely in the private market, encourage integrated networks of care, and require little federal regulation. In fact, it would actually mean less regulation than the leading managed competition plan because it does not mandate that insurers and providers join regional integrated care networks.

At the same time, this bill has a binding cost control mechanism which is simpler, less regulatory and less unwieldy than a global budget. A National Health Commission would create the benefit package and establish a base premium rate insurers could charge for it. The Commission would then set annual limits on premium rate increases. The price cap combined with insurance market reform puts the emphasis on efficiency and cost effectiveness rather than risk selection. It will be in carriers and providers best interest to form managed care networks and to compete for consumers within the private insurance market. The beauty of this approach is that it provides binding cost control with a minimum of government regulatory interference in the health care marketplace.

I understand your health care working groups are giving serious attention to the cost control mechanism embraced by my bill. I urge you to look at the BASICARE approach, which lays out a logical and manageable way to use premium rate caps in a managed competition environment to bring down health care costs for all Americans.

In the coming days you will be hearing from my co-sponsors of this bipartisan initiative because they, like I, believe BASICARE is the best compromise between managed competition and global budgeting that still ensures universal coverage.

I look forward to discussing this approach with you or one of your representatives. In addition, I would be happy to put together a meeting with the five Senate and House sponsors of the BASICARE bill if you wish to meet with a bipartisan group. I have enclosed a copy of the bill, a brief summary, and a detailed outline of the BASICARE bill. I would be happy to provide any additional information you might require.

Again, I hope you will give this bill serious consideration as we all work together to find a solution to our nation's health care crisis.

With best regards,

DAN GLICKMAN
Member of Congress

DG:mhf
Enclosures
This bill (the only bi-partisan bill around, by the way) basically treats the health insurance industry as if it were a regulated public utility. It may be useful to consider health care in the same model or paradigm as we consider public utilities -- regulated but not government managed.

"BASICARE" HEALTH ACCESS AND COST CONTROL PLAN
Congressman Dan Glickman

The Basicare bill is a national health insurance plan which makes affordable health coverage available to everyone, controls health care costs, and reforms a system which is breaking down.

UNIVERSAL ACCESS:

* This bill simplifies the insurance market by establishing a single, nationally uniform "Basicare" package of health benefits that all Americans will carry. The package would include, but would not be limited to, coverage of:

  * basic hospitalization
  * basic outpatient services
  * catastrophic out-of-pocket costs
  * extraordinary long-term care costs
  * prescription drugs
  * periodic health examinations and other preventative care services

* The Basicare package will be developed by a full-time national commission of independent experts appointed by Congress and the President. Similar to the current military base-closing system, Congress will have the power to vote up or down on the commission's recommendations, but not to amend them. This will ensure Congress remains accountable for health care policy, while experts handle the complicated, sensitive task of overseeing the nation's health care system. Most importantly, the commission will be insulated from political pressure and special interest groups.

* Americans will purchase Basicare from insurance carriers. Any insurance carrier wishing to sell health insurance will have to offer the Basicare plan and adhere to its conditions. The carrier may not offer any policy that duplicates Basicare in any way. Insurers may, however, offer supplemental policies for persons wishing greater coverage beyond that provided by Basicare.

* To protect beneficiaries, Basicare premiums will be the same for individuals and groups, and insurance companies will be required to guarantee acceptance of all applicants. Insurers will not be allowed to raise a person's premiums because of illness or deny coverage because of a "pre-existing" medical condition. In addition, BasiCare will be portable so employees do not have to fear loss of coverage should they change or lose their job.

* The low-income uninsured will purchase Basicare insurance with non-transferable vouchers. The amount of a voucher a family or individual receives will be based on a sliding scale and will reflect the percentage of the Basicare costs they can afford. Even persons receiving full voucher assistance will be required to pay a small per-service copayment to discourage overutilization.

* The new voucher program will replace and expand upon the current Medicaid program, and the new Basicare system will be expanded over time to encompass Medicare.

* To further target services to low-income and underserved, rural populations, this bill expands funding and access to community health centers and other community-based primary care facilities. To increase the number of health care professionals in medically underserved areas, it expands funding for the National Health Services Corps and provides targeted tax incentives to doctors, nurses, and other health care professionals practicing in underserved rural communities.

COST CONTAINMENT:

* Control of health care costs will be maintained through binding limits on BasiCare's annual premium rate increases, which will be set by the Commission.

* The bill requires standardized billing and claims paperwork to cut down on unnecessary paperwork and administrative costs.

* In addition, there are tough malpractice liability reforms and changes in anti-trust laws to allow hospitals and doctors to share costly medical equipment and technology.

* The combination of a standard benefits package and premium rate caps puts insurers at risk for rising health care costs. They will be forced to form risk pools and organized care relationships with providers to share financial risks and keep costs down. Providers, in order to retain patients and receive payment, will have to negotiate fees or salaries with insurers.

SYSTEM REFORM:

* Changes would be made in the tax laws to make the system more equitable and to help finance access for the poor.

* Employers who provide coverage for their employees will be allowed a 100% deduction for the Basicare package only. Similarly, employees will only receive tax exclusion for the Basicare package.

* Self-employed individuals, farmers, and those who purchase insurance privately will be able to deduct 100% of the cost of Basicare.

* Additional funding to finance Basicare would come from a taking 1% of the **current** Social Security payroll tax. 85% of the 37 million uninsured Americans are working and paying payroll taxes. Because 1.4% of the FICA tax goes into Medicare, they are paying for someone else's health insurance when they cannot afford their own. The Social Security Trust Fund has a $200 billion surplus which is being used to mask the size of the deficit. Our inefficient health care system contributes annually to the size of the deficit, so it makes sense to use 1% of the Social Security tax to provide health care for those paying it.

* The assumed end result of this type of approach to health care reform is a nation-wide system of managed health care partnerships between insurers and providers competing for consumers on price, quality of care and efficiency. Costs to consumers will necessarily be kept down because of premium rate caps, but they will also be kept low through competition among insurers. Competition does not exist in our current system.

* Government's role in this approach will be limited. The Basicare package will be defined and standardized by the government, but its administration and financing will remains in the private sector. This approach combines the simplicity, stability and cost-control with the private market incentives that are necessary to ensure quality and innovation in American medicine. It means cost control without federal or state micro-management of rates and fees.

SPECIFIC DETAILS ABOUT THE BASICARE BILL (H.R. 834):

A. CREATION OF BASICARE: THE PACKAGE

1. Congress will determine the broad foundation of the BasiCare package, but Congress will not be directly responsible for the details of the plan's composition. Among the foundations that Congress would require, however, will be:

   a. Basic hospitalization coverage;

   b. Basic outpatient services;

   c. Protection against catastrophic out-of-pocket costs;

   d. Coverage against extraordinary long-term care costs; and

   e. Coverage of prescription drugs (with the reasonable cost sharing)

   f. Coverage for periodic health examinations and other preventive care services to the extent determined to be of significant proven and recognized value in averting serious and costly medical conditions.

2. The Basicare package shall provide for uniform national deductibles, copayments, and benefit applications and standards. Limited variation may be allowed at Commission's discretion. When practicable, the Commission shall employ copayments rather than deductibles to ensure cost-sharing.

THE COMMISSION: ITS COMPOSITION

1. Actual development of the BasiCare package will be conducted by a nine-member independent, expert commission. Five of the members will be appointed by the President, and the other four by the congressional leadership. All will serve on a full-time basis for five year terms. At no time will more than five members be affiliated with the same political party.

2. Membership of the Commission shall consist of individuals with substantial knowledge or expertise in health care delivery, health care insurance, or health care economics. No employee of the U.S. government may serve on the Commission.

3. The Commission shall appoint a 15 member National Advisory Board to carry out duties assigned by the Commission. Each member shall serve 3 years and members will be representatives of employers, unions, health care providers, health care carriers, consumer organizations, State health programs, and public health professionals, as well as the general public.

4. The Commission shall appoint a Managed Care Advisory Committee. The Committee shall be composed of 5 uncompensated members one each representing health care professionals, managed care industry, academia (with specific expertise in managed care plans), business management, and organized labor.

THE COMMISSION'S DUTIES:

1. The Commission will define a benefit plan which, in its judgment, represents a minimum but fair coverage package.

2. As under the current system for closing military bases, Congress will have the power to approve or disapprove the Commission's recommendations, but only as an un-amendable package. The purpose of this mechanism is to help assure that the process of developing the benefit package is not unduly distorted by political pressure.

3. The BasiCare Commission will have authority to make adjustments in the plan's content, as needed, to reflect changes in technology or in the nation's health needs. It will also have significant oversight responsibility for the health care system as a whole.

4. The Commission shall establish federal certification guidelines to ensure carriers marketing "BasiCare" plans are adhering to benefits, underwriting, and cost requirments. The Commission may contract with the States for actual administration of the certification process.

5. The Commission will establish a BasiCare base premium rate for the first year of standardization. This will be based on the anticipated average cost of providing the BasiCare benefits package to an average group of beneficiaries. The Commission may allow for variation in the base rate to accommodate geographic and limited other variables.

6. Insurers will be required to limit annual increases in BasiCare premiums to a federally defined maximum percentage. More specifically, the BasiCare Commission each year will set a maximum allowable percentage for such premium increases. This percentage will be binding on all insurers.

7. Risk-adjustment: The Commission will establish broad national standards for risk-adjustment among BasiCare plans, but the actual management of such adjustment would be handled at the state level by state insurance departments. All BasiCare plans in a state would be given a numerical risk index based on an assessment of the age, sex, and claims history of their enrollee population. Plans with lower-risk (i.e. less expensive) enrollee populations would pay an assessment to the state, which, in turn, would be used to provide compensating subsidies to those plans with higher-risk populations.

8. To guard against potential abuses of the supplemental market, the BasiCare Commission is given strong oversight authority to monitor behavior in the new supplemental market and submit legislation to Congress providing for explicit consumer protection or cost controls should market abuses or unreasonable cost growth develop.

9. The Commission will have oversight over the pharmaceutical industry and would have authority to draft legislation suggesting methods to control prescription drug prices. Congress, again, would be able only to vote up or down on any such legislation.

10. The Commission will be charged with ongoing oversight of the quality of health care delivery--particularly as the system reacts to implementation of the new BasiCare structure. The Commission will be required to factor findings on quality into any recommendations it makes to Congress on the content or the cost of the BasiCare package. It will also be authorized to contract with local and regional entities for the collection and dissemination of health care quality and cost data to consumers. Information to be gathered would include: 1) the degree to which a plan's practice patterns agree with what is known about appropriate and inappropriate approaches to care, 2) outcome rates for patients with particular conditions, and 3) patient satisfaction with various aspects of a plan's performance.

11. Paperwork standardization: The Commission will be responsible for creating standardized billing and claims paperwork for Basicare which will be uniform across all carriers. The Commission shall develop an electronic universal health insurance card for every individual and family for the purposes of payment and billing.

12. Within 5 years of passage of the this bill, the Commission shall submit to Congress draft legislation providing for the assimilation of the Medicare program. The Commission shall follow the same procedure for assimilating CHAMPUS and the Federal Employees' Health Benefits Plan (FEHBP).

13. Taking into account recommendations of the Managed Care Advisory Committee, the Commission shall develop recommended standards that carriers offering managed care plans should meet with respect to the benefits, coverage and delivery systems provided under such plans. Such standards shall encompass the standards by which managed care entities operate.

B. BASICARE'S ROLE IN THE INSURANCE MARKET:

1. All insurers in the health insurance market will be required to offer BasiCare and to accept its conditions.

2. Requirements under the BasiCare health benefits plan will preempt State and local government regulations and requirements relating to insurance benefits, except State information requirements.

3. Insurers will be barred from selling non-BasiCare policies that duplicate BasiCare benefits in any way.

4. When the program is fully implemented, BasiCare policies will be subject to strict rating and underwriting rules aimed at assuring availability and curbing risk selection. These will include:

   a. Guaranteed Issue and Renewal: Insurers offering a BasiCare health benefit plan to groups or individuals located in a community must offer the same plan to any other group or individual located in the community, and shall participate in a program developed by the Commission for assigning high-risk groups or individuals among all such carriers. The same standards will apply to policy renewal. A carrier may refuse to issue, renew or terminate a BasiCare benefit plan only for nonpayment of premiums, fraud or misrepresentation, failure to meet minimum participation rates, and termination of business.

   b. Treatment of Preexisting Conditions: BasiCare health benefit plans provided by carriers may not exclude or otherwise discourage coverage with respect to services related to treatment of a preexisting condition.

   c. Community Rating: Insurers will be required to set rates on the same terms to all BasiCare policyholders, both group members and individuals. Adjustments in community rating will be permitted > for the age of covered individuals. Any such adjustment shall be applied by the carrier consistently to all policyholders, and no other adjustments shall be permitted.

   d. Plan Period: A carrier may not offer or issue a BasiCare health benefit plan with a term of less than 12 months, and a carrier may not change the BasiCare premium rates in a community more often than monthly.

   e. Portability: Persons will no longer have to fear lack of access to coverage due to a change in employment.

5. For the first year of standardization of the BasiCare health benefit plan, premiums charged for BasiCare health benefits plans may not exceed the BasiCare base premium rate -- set by the Commission based on the anticipated average cost of providing the BasiCare package to an average group of beneficiaries.

6. A BasiCare carrier may not charge BasiCare premiums which exceed the greater of the previous year's rate plus the annual allowable percentage rate of increase or the base premium rate plus the amounts corresponding to the cumulative total of annual allowable percentage rates of increase up to the current year.

7. Each carrier shall register with and have its BasiCare plan certified by the applicable regulatory authority for each State in which it issues or offers health benefit plans.

8. TREATMENT OF HMOs: An HMO may deny coverage under a Basicare plan to an individual or group whose members are located outside the service area of the organization, but only if such denial is applied uniformly without regard to health status or insurability. An HMO may also apply to the State regulatory authority to cease enrolling new individuals or groups if its administrative or financial capacity to serve will be impaired.

9. Carriers will be able to sell supplemental policies for services not covered by BasiCare. Leaving room in the market for a supplemental insurance market will serve a dual purpose. First, it will allow persons or groups the freedom of choice to tailor coverage to their own particular needs. Second, a private supplemental market will provide greater incentives for the development of innovative treatments than might be the case were BasiCare the only available option.

10. Insurers failing to comply with the above reforms will be subject to a federal excise tax equal to 50% of gross premium income. The tax would not apply if the carrier did not know of the failure or if the failure is due to reasonable cause and is corrected within 30 days of the carrier becoming aware of the failure.

EMPLOYER RESPONSIBILITIES UNDER BASICARE:

1. An employment-related BasiCare health benefit plan may not deny, limit, or condition coverage based on the health status, claims experience, receipt of health care, medical history, lack of evidence of insurability, or because of services related to treatment of a preexisting condition.

2. An employment-related BasiCare health benefit plan may not impose waiting periods of any length.

3. An employment-related BasiCare health benefit plan shall apply equally to employees of all income levels.

4. The total amount of an employer's contribution to the cost of coverage under BasiCare for employees with incomes less than 200 percent of the income official poverty line shall equal or exceed such total amount for employees with incomes greater than 200 percent of the poverty line.

5. A tax will be imposed on any employer failing to comply with the above BasiCare requirements. With respect to a full-time employee, the tax shall be $50 for each day of the noncompliance period. The noncompliance period shall begin on the date the failure first occurs and shall end on the date such failure is corrected.

PROVIDERS' RESPONSIBILITIES UNDER BASICARE:

1. The costs of delivery will come down because of the incentives for insurance carriers to form managed care relationships with providers.

2. Providers must accept as payment in full whatever reimbursement level (or capitated payment) they have contracted with BasiCare plans.

3. Providers will be assessed a tax of 50% of gross income for failure to comply with the law. The tax will not apply if the provider was unaware of the failure or if the failure was due to reasonable neglect and is corrected within 30 days of the provider becoming aware of the failure.

INDIVIDUAL RESPONSIBILITIES UNDER BASICARE:

1. To be eligible for benefits under any Federal program, an individual seeking benefits must certify to the administrator of the programs that the individual and the dependents of the individual posses BasiCare health insurance coverage.

2. The personal exemption amount for any individual shall be zero unless the policy number of the BasiCare health benefit plan for that individual is included on his or her federal tax return.

SELF-INSURED PLAN REQUIREMENTS:

1. No self-insured BasiCare health benefit plan may be offered unless the plan has been certified by the Commission as qualifying as a BasiCare health benefit plan.

2. Certification requirements:

a. the benefits and conditions of such plan (including copayments and deductibles) are substantially equivalent to those of a Basicare health benefit plan.

b. the self-insuring entity is adhering to nondiscrimination standards substantially equivalent to those provided for carriers, including non-discrimination based on health status, and treatment of preexisting conditions. No waiting periods will be allowed.

c. the average per capita cost of providing BasiCare equivalent benefits to enrolles differs no more than 10 percent (either above or below) from the average per capita cost of providing BasiCare benefits package to non-self-insured beneficiaries in the community in which the self-insured group is located. An exception will be made if the entity adequately demonstrates to state insurance authorities that their lower costs are due to factors other than favorable risk characteristics (i.e. wellness programs, smoking cessation, etc.)

d. the self-insuring entity posses adequate financial reserves, as determined by the Commission, to assure the immediate and long-term solvency of the entity and the benefits of individuals receiving coverage through such entity.

3. These requirements shall only apply to coverage for benefits equivalent to the BasiCare health benefit plan and do not apply to other, supplemental health benefits.

PROVISIONS RELATING TO MANAGED CARE:

1. The Commission, taking into account recommendations of the Managed Care Advisory Committee, shall develop recommended standards that carriers offering managed care plans should meet with respect to the benefits, coverage, and delivery systems provided under such plans. Such standards shall encompass the standards by which managed care entities operate.

2. In the case of a managed care plan meeting the recommended standards , the following provisions of State law are preempted and may not be enforced against the managed care plan with respect to a carrier offering such plan:

a. Any law that restricts the ability of the carrier to negotiate reimbursement rates with health care providers or to contract selectively with one provider or a limited number of providers.

b. Any law that limits the financial incentives that the managed care plan may require a beneficiary to pay when a non-plan provider is used on a non-emergency basis.

c. Any law that:

(i) prohibits utilization review of any or all treatments and conditions;

(ii) requires that such review be made by a resident of the State in which the treatment is to be offered or by an individual licensed in such State, or by a physician in any particular specialty or with any board certified specialty of the same medical specialty as the provider whose services are being rendered;

(iii) requires the use of specified standards of health care practice in such review or requires the disclosure of the specific criteria used in such review; requires payments to providers for the expenses of responding to utilization review requests;

(iv) or imposes liability for delays in performing such review.

(v) a State may require that utilization review be conducted by a licensed health care professional, or may require that any appeal from such a review be made by a licensed physician or by a licensed physician in any particular specialty or with any board certified specialty of the same medical specialty as the provider whose services are being rendered.

d. Any law that mandates benefits under the managed care plan that are greater than the benefits recommended by the Commission.

LOW-INCOME ASSISTANCE:

1. TRANSFER FROM MEDICAID TO BASICARE:

A. The Commission shall provide for the orderly termination of Medicaid program coverage to the extent that such coverage duplicates the BasiCare benefits package.

B. For a period of 5 years following the termination of Medicaid benefits that duplicate the BasiCare benefits package, the Medicaid program shall continue to operate with respect to the provision of any existing benefits which are not covered under the BasiCare benefits package.

C. Federal rules and regulations regarding the Medicaid program shall remain in effect during a transition period subject to such adjustments deemed necessary by the Commission to carry out the Medicaid-to-BasiCare transfer.

D. Upon expiration of the 5-year transition period, Federal funding for any existing Medicaid benefits which are not covered under the BasiCare benefits package shall be discontinued, unless Congress has approved a plan for alternated disposition of such benefits.

E. The switch from Medicaid to BasiCare will assure that medical providers are no longer reimbursed at a lower level for treating low-income patients, as they are under the current Medicaid system.

F. Most federal and state funding currently going to Medicaid will be transferred to the BasiCare low-income assistance program.

2. LOW-INCOME ASSISTANCE WITH COSTS OF BASICARE INSURANCE:

A. The Commission shall provide for a BasiCare public assistance program. In the case of an under-poverty individual, the BasiCare assistance shall provide a non-transferable voucher for payment of BasiCare premiums and deductibles and other cost-sharing imposed on the individual, other than a per service copayment, not to exceed $5 per service.

B. In the case of a member of a near-poverty family, BasiCare Assist shall provide for payment of the applicable percentage of any premiums, deductibles, and other cost-sharing charged under BasiCare through non-transferable federal vouchers redeemable directly to BasiCare carriers or employer plans. The applicable percentage means 100% reduced by 10 percentage points for each 10 percentage point bracket such family's income equals or exceeds 100% of the income official poverty line.

C. The BasiCare Assist shall use a standard Federal application which shall be as simple in form as possible and understandable to the average individual.

D. To facilitate "one-stop shopping" for recipients, the process of application and approval for assistance will be coordinated with actual enrollment in a BasiCare plan.

E. This legislation specifies minimum income levels for which voucher assistance must be provided, but it leaves the commission discretion to propose increases in these levels, as it may deem appropriate to correspond with the new BasiCare benefits package. At a minimum, persons below 100 percent of the federal poverty line will receive full voucher assistance, and persons between 100 and 200 percent of the poverty will receive assistance on a sliding scale based on income. Importantly, even persons receiving full voucher assistance will be required to pay a small per-service co-payment to discourage overutilization.

F. Individuals who deliberately falsify or misrepresent information on an application for assistance shall be liable for financial penalties to be paid to the Federal Government.

FINANCIAL PROVISIONS:

1. The Treasury shall create a Basicare Trust Fund, into which shall be appropriated:

A. A limited draw of funds from the current Social Security payroll tax, not to exceed 1 percent of the tax: The Social Security payroll tax is now set at a level higher than is necessary to assure adequate reserves for present and future retirees. As the consumer group Families U.S.A. and others have argued, it is appropriate that at least a modest portion of these resources be devoted to the very useful purpose of overhauling our declining health care system. Just 1 percent of the current tax would equate $56 billion a year in 1996, and even more as time goes by. This provision would go into effect on the first day of the calendar year after enactment.

B. An identical limited draw of 1 percent of the amount of self-employment income. This provision would go into effect on the first day of the calendar year after enactment.

C. Limiting the tax deduction and exclusion for employer contributions to employee benefit plans: Under current law, 100 percent of employer payments to employee health plan are deductible to the employer and tax-exempt to the employee. This will be changed to allow such deduction and exemption only for contributions associated with BasiCare coverage. Additional payments for supplemental coverage will be taxable.

D. "Capturing" existing Medicaid funding: As Medicaid is replaced by BasiCare, its current funding will be restricted to amount needed to fund the BasiCare benefits package. At the federal level, this will be accomplished by posting existing Medicaid expenditures to BasiCare and indexing the amount upward each year according to inflation. Similarly, the states will be required to contribute to BasiCare an amount proportionate to their current Medicaid match. This, too, will be indexed upward with inflation.

E. Capturing CHAMPUS Funding: As CHAMPUS is folded into the BasiCare system, the amounts equal to the amounts appropriated for CHAMPUS each year.

2. It will be the duty of the Secretary of the Treasury to invest such portion of the Trust Fund as is not, in the Secretary's judgement, required to meet current withdrawls.

3. All individuals may deduct 100% of the cost of the BasiCare package (minus contributions from the federal government, employers or any other source) from federal taxation.

COST-CONTAINMENT THROUGH BASICARE: The BasiCare system will put in place several strong levers for maintaining cost-control in the health care system. These include:

1. The benefit package itself: The BasiCare commission will be charged with limiting the scope of benefits to a reasonable minimum. Recognizing that defining a core is necessarily a subjective and difficult task, the commission will nevertheless be largely insulated from the strong provider and consumer pressure that has led for example, to expensive state benefit mandates under the current system.

2. Global restraint of BasiCare premium increases: Insurers will be required to limit annual increases in BasiCare premiums to a federally defined maximum percentage. More specifically, the BasiCare Commission each year will set a maximum allowable percentage for such premium increases. This percentage will be binding on all insurers. States would have the authority to lower the annual increase but not raise it.

   As it initiates this system of premium increase limits, the BasiCare commission will also have authority to establish an average base premium for the BasiCare package from which future allowable increases will be measured. This is to guard against the possibility of insurers setting initial rates unreasonably high in anticipation of future increase limits. The Commission will be permitted to apply limited geographic variation in the base rate to reflect regional differences in the cost of providing the BasiCare package.

   By establishing a single maximum allowable percentage of increase, government will be putting insurers themselves at risk for rising costs, thereby creating a strong incentive for efficiency. The government's role will be simply to set the overall budget parameters; responsibility for finding the best way to live within these means will be left to the health care system itself. Unlike other cost-control proposals, this approach will avoid the pitfalls of government micromanagement of specific insurance rates and provider fees.

   It is likely that insurers will react to the new budget controls by forming organized care relationships with providers in order to share the financial risk with those providers. Under such arrangements, both insurers and providers will have a direct financial stake in keeping costs down and delivering care as efficiently as possible.

3. Oversight of provider billing: It is anticipated that the BasiCare premium limits described above will create a market situation in which the only way either providers or insurers can survive financially will be to enter into organized networks of care with each other, under which provider payment would be limited to the negotiated amount.

   However, to guard against the possibility of unreasonable provider overcharges to consumers, providers must accept as payment in full whatever reimbursement level (or capitated payment) they have contracted with BasiCare plans.

EXPANSION OF COMMUNITY HEALTH SERVICES:

-- New federal funding will be allocated for Community Health Centers (CHCs) and for other state and local public health clinics. Such centers have a good record of providing inexpensive, cost-effective treatment to indigent and low-income persons. Authorization is $600 million annually in new funding for these programs.

-- Funding for this provision would come from the BasiCare Trust Fund.

MALPRACTICE REFORM:

1. Provides federal preemption for comprehensive medical liability reforms, including mandatory periodic payment of future awards, limits on awards for non-economic ($250,000) and punitive damages (no greater than total award of compensatory damages), reducing awards by the amount of compensation from collateral sources, and court determination of reasonable attorneys' fees;

2. Joint and several liability shall apply to the liability of each defendant for damages for economic loss and as between persons acting in concert where the concerted action proximity caused the injury. Joint and several liability shall not apply to the liability of each defendant for damages for noneconomic losses.

3. Except for minors, no health care liability action may be initiated after the expiration of the 2-year period that begins on the date on which the alleged injury should reasonably have been discovered, but in no event later than 4 years after the date of the alleged occurrence of the injury.

JOINT USE OF EQUIPMENT AND SERVICES:

1. Clarifies antitrust law regarding joint service ventures to facilitate collaboration among hospitals for the purpose of sharing expensive high technology equipment or services.

2. Specifically, this provision amends the National Cooperative Research Act to allow joint service ventures by two or more hospitals for the delivery of costly services. It will apply the rule-of-reason standard to joint service ventures that are challenged, allowing the court to consider the competitive benefits of the venture.

EXPANDING THE SUPPLY OF HEALTH PROFESSIONALS IN RURAL AREAS:

1. Significantly expands funding for the National Health Service Corps, a program to place doctors and other health professionals in underserved areas in exchange for scholarship or loan repayment assistance. Authorization is $120 million for each of the next five years.

2. Funding for this provision would come from the BasiCare Trust Fund.

3. Physicians will be allowed a tax credit equal to $1,000 a month for practice in a rural health professions shortage area. Nurse practitioners and physician assistants will be eligible for a similar credit equal to $500 per month.

3. Provides additional tax incentives for rural practice, including deductibility of National Health Service Corps loan repayments and deductibility for the cost of basic medical equipment.