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MEMORANDUM

TO: The President

FROM: Senator Mitchell

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SUBJECT: Follow up on July 21 Health Meeting

DATE: July 22, 1994

During our meeting last night you asked for additional information about (1) why an employer mandate system costs more than a system without a mandate, and (2) how a system without a mandate could achieve 95 percent coverage. Outlined below is some further information on these two issues.

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Costs of a Mandate:

A mandatory system is more expensive than a system without a mandate for a couple of reasons.

First, since virtually all Americans would have health care insurance under a mandatory system, the federal government would be subsidizing more individuals and employers than it would under a non-mandate system. We hope, for example, that a system of targeted subsidies would expand coverage to about 95 percent of the population. While this represents a substantial increase over current levels, it would still be less than the 98 or 99 percent coverage that would be achieved under a mandatory system. This extra three or four percentage points represents 8-10 million people, most of whom would be eligible for federal subsidies. Providing these subsidies under a mandatory system would increase federal costs substantially. For example, adding a mandate to one voluntary plan currently under review would increase the plan's ten year costs by $138 billion.

A second reason why a system with an employer mandate is more expensive relates to the efficiency and generosity of employer subsidies typically available in a mandatory system. Most mandatory proposals include subsidies for employers which would cap employers' premium payments at a certain percent of each worker's income. While these employer subsidies tend to target lower income workers, they are available to all employers, including those currently offering insurance to their lower wage workers. Such a subsidy regime tends to be less efficient than employer subsidies under a voluntary system, which are usually limited to currently uninsured workers.

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95 Percent Coverage under a Voluntary System:

The proposal which I am now considering includes additional targeted subsidy programs that should bring the percentage of the population with insurance up to at least 95 percent. That legislation would include the following targeted subsidy programs:

- Low-income subsidies for the general population that phase out between a range of 75 percent and 200 percent of poverty. This would include an outreach program whereby individuals presumptively eligible for full subsidies (those at less than 75 percent of poverty) would be signed up for health insurance at the point of service. This subsidy is estimated to reduce the number of uninsured by about 10-12 million people, raising the percentage of the population covered by about 4-5 percent.

- The purchase of health insurance for AFDC recipients that find work would be fully subsidized for two years. Currently they are fully subsidized for one year. It is estimated that this would increase coverage by about 2 million people, raising the percentage of the population insured by a little less than 1 percent.

- The income of insured working individuals who become unemployed would be calculated by disregarding unemployment insurance income and 75 percent of their job income. This would make more unemployed individuals eligible for the low income subsidies, thus increasing coverage. It is estimated that this would increase the number of insured by about 4 million people, raising the percentage of the population insured by a little less than 2 percent.

- The Riegle amendment to the Finance-reported bill would be included to provide higher subsidies to pregnant women and children. It is estimated that this would increase the number of insured by about 4 million people, raising the percentage of the population insured by about 2 percent.

- Two employment based subsidies would be provided to encourage employers to expand coverage. The first would provide employers of any size a subsidy on their share of the premium up to 50 percent so that such premium does not exceed 8 percent of an individual employee's wages. This would only be available for those employees not now covered, where health insurance is offered to all workers in the firm. The second program would be targeted to firms with under 25 employees who do not now provide coverage. It would permit the employer to share in both the low income household subsidies and the 8 percent of wage employer subsidies where insurance coverage is offered to all employees. It is estimated that these programs together would increase the number of insured by about 4 million people, raising the percentage of the population insured by somewhat less than 2 percent.

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In total these targeted subsidy programs would increase the number of insured by about 25-27 million people, leaving about 13 to 15 million people uninsured. The percentage of the population with insurance would rise to about 95 percent.

These numbers are consistent with the work of CBO on the Cooper bill. That legislation provides for a system of household subsidies that pay for the full cost of health insurance for families below poverty. The subsidies are phased out between 100 and 200 percent of poverty. CBO estimated that this would result in an increase in the percentage of the population with insurance from 85 percent to 91 percent.

The Finance Committee reported bill includes the same subsidies, plus a program added in a Riegle amendment that provides more generous subsidies for the purchase of health insurance by pregnant women and children. Under this provision, full subsidies for this population would be provided up to 185 percent of poverty, phased out by 240 percent of poverty. Although CBO has not yet released its analysis of the Finance bill, the Riegle provision should increase coverage by another 2 percent. That would mean the Finance Committee bill would increase the percentage of the population with insurance to 93 percent.

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6/27/94
12:15 p.m.

MAINSTREAM COALITION PROPOSED AGREEMENT

PART ONE - COVERAGE

I. INSURANCE COVERAGE

This section guarantees access to Qualified Health Plans for all U.S. citizens and lawful residents not covered under other public programs such as Medicare, Medicaid, CHAMPUS and DVA. This section details the establishment of Health Care Coverage Areas (HCCAs), institutes insurance market reforms, establishes standardized benefits packages, creates Qualified Health Plans (QHP), establishes eligibility for low-income assistance vouchers and expands tax deductibility of health insurance premiums.

A. Assurance of Universal Coverage

1. A National Health Commission (as described in Section XIV.) must report to Congress biennially on the status of health insurance coverage in the nation. The report must include, but is not limited to, the structure and performance measures of every market area, including the following:

   a. Demographics of the uninsured, and findings on why those individuals are uninsured;

   b. Structure of delivery system;

   c. Number, organizational form of health plans;

   d. Level of enrollment in health plans;

   e. State implementation of responsibilities, including establishment of coverage areas;

   f. Status of insurance reforms;

   g. Development of purchasing groups and other buyer reforms;

   h. Success of market and other mechanisms of controlling health expenditures and premium costs in the market area and nationally;

i. Status of transition of Medicaid toward managed care and integration into AHPs;

j. Adequacy of subsidies for low income individuals;

k. Status of Medicare beneficiaries, transition into Medicare managed care and QHPs;

l. Coverage progress among those who are employed, including status and level of voluntary employer contributions and participation rates in pools and among large employers;

m. Percentage of individuals who are enrolled in Qualified Health Plans, separated into categories of Medicare, Medicaid, employed individuals and individuals eligible for low-income subsidies;

n. Informal recommendations, specific to each market area, on how the area might increase coverage among the residents and further moderate growth in premiums; and,

o. Evaluation of adequacy of benefit packages.

B. Coverage Trigger

1. Establishes a national goal that 95% of all Americans will have health care coverage by 2002.

2. If this goal is not met, the Commission must submit formal and specific recommendations to Congress by January 1, 2002 as draft legislation. The recommendations shall include methods to reach 95% coverage in market areas that have failed to meet that target. They must address all relevant parties, including states, employers, employees, unemployed and low income individuals, public program beneficiaries, etc.

3. In addition to any other recommendations it submits, the Commission must make separate recommendations on the following:

   a. A schedule of assessments or contributions to encourage employers who are not doing so to purchase coverage for their employees;

   b. A method of encouraging full coverage which does not require any assessments on or contributions from employers;

c. Possible adjustments to the benefits package;

d. Possible adjustments to subsidies; and,

e. Possible adjustments to tax treatment of benefits.

4. Congressional Consideration of the National Health Care Commission Report. This proposed process is being reviewed by the Senate and House Parliamentarians.

A. Rules for the Senate

1. The Majority Leader must introduce the Report as a bill on the first day of session following the submission of the Report and legislative language. If the Majority Leader has not introduced the bill within five days of session, any Senator may do so.

2. The bill will be referred to the appropriate Senate Committee.

3. If the Committee fails to report the legislation by July 1, 2002 (or if the Senate is not in session on this date, by the first day of session after this date), it shall be automatically discharged from further consideration of the bill; and the bill shall be placed on the appropriate Senate calendar.

4. Within 5 session days after the bill is placed on the calendar, the Majority Leader, at a time to be determined by the Majority Leader in consultation with the Minority Leader, shall proceed to the consideration of the bill.

If on the sixth day of session, the Senate has not proceeded to consideration of the bill, then the presiding officer must automatically put the bill before the Senate for consideration.

5. 30 Hours of consideration

a. Two hours for first degree relevant amendments

b. One hour for each relevant second degree amendment.

c. 30 minutes on each debatable motion, appeal, or point of order submitted by the presiding officer to

the Senate and no motion to recommit shall be in order.

6. There shall be five hours of consideration of motions and amendment appropriate to resolve the differences between the Houses, at any particular stage of the proceedings.

B. Rules for the House of Representatives

1. The Majority Leader must introduce the Report as a bill on the first day of session following the submission of the Report and legislative language. If the Majority Leader has not introduced the bill within five days of session, any Member may do so.

2. The bill will be referred to the appropriate House Committee or Committees.

3. If the committee or committees fails to report the legislation by July 1, 2002 (or if the House is not in session on this date, by the first day of session after this date), they shall be automatically discharged from further consideration of the bill.

4. On the sixth legislative day (the day on which the House is in session) after the date on which the bill has been placed on the appropriate calendar, it shall be privileged for any Member to move that the House resolve itself into the Committee of the Whole House on the State of the Union, for the consideration of the bill, and the first reading of the bill shall be dispensed with.

5. After general debate, which shall be confined to the bill and which shall not exceed four hours, to be equally divided and controlled by the Chairman and Ranking Minority Member of the Committee or Committees to which the bill had been referred, the bill shall be considered as read for amendment under the five-minute rule. The total time for considering all amendments shall be limited to 26 hours of which the total time for debating each amendment under the five minute rule shall not exceed one hour.

6. At the conclusion of the consideration of the bill for amendment, the Committee shall rise and report the bill

to the House with such amendments as may have been adopted, and the previous question shall be considered as ordered on the bill and the amendments thereto to final passage without intervening motion except one motion to recommit.

C. Health Care Coverage Area

The major vehicle for reorganizing the health care marketplace would be the establishment of geographic areas called Health Care Coverage Areas (HCCAs). Employees of employers with fewer than 100 employees and individuals residing or working in the HCCA would be pooled together and would be eligible for insurance at an age-adjusted community rate. HCCAs are established by each state and a minimum number of 250,000 lives must be included in the HCCA rating pool. States may enter into cooperative agreements to establish interstate HCCAs. States may decrease the number of covered lives included in a rating pool.

Within each HCCA, consumers will have several different options available to purchase health insurance. Employers and individuals may purchase coverage directly from an insurer or agent, they may enroll at designated state enrollment sites or they may chose to join a purchasing cooperative. Accountable Health Plans may charge different administrative (or enrollment) fees depending upon how the plan is purchased. If a Point of Service (POS) Option plan is not available in the HCCA in which an individual lives or works, the individual may purchase such a plan in an adjacent HCCA.

D. Insurance Market Reforms

The Secretary of HHS shall, within six months of enactment, and in consultation with private expert entities such as the National Association of Insurance Commissioners (NAIC), develop federal standards with which Qualified Health Plans must comply in order to be deductible by an employer or an individual. While these federal standards will be established by the Secretary of Health and Human Services, the enforcement will be by the state or the Department of Labor depending on the nature of the Qualified Health Plan. All Qualified Health Plans must:

1. Guarantee issue to all qualified applicants.

2. Guarantee availability throughout the entire area in which it is offered.

3. Guarantee renewal to all qualified enrollees, except in instances of non-payment of premiums or fraud or misrepresentation.

4. Not deny, limit, or condition coverage based on health status, claims experience, or medical history during the annual open enrollment period. The bill includes a first-time enrollment amnesty extended for a certain period after the date of enactment. Individuals are encouraged to maintain continuous coverage. Continuous coverage means that the period between the date of enrollment in a health plan and the last date of coverage may be no longer than three months. If an individual has not maintained continuous coverage or is enrolling in a plan for the first time after the initial open enrollment period, coverage may be subject to a pre-existing condition limitation of no more than six months. Pregnancy and pre-natal care are exempted from this limitation.

5. Comply with all rating requirements, including age and family size adjustments, within the coverage area. (Special rules will be established to apply to Employer Sponsored Heatlh Plans and Qualified Association Plans).

6. Comply with enrollment process.

7. Comply with financial solvency requirements, premium and collection criteria. (Special solvency rules are established for certain types of plans for large employers).

E. **Benefit Packages**

1. Within six months of enactment, the Commission (described in Section XIV.) shall develop and submit to the Congress clarification of the initial standard and basic benefits packages. These packages must adhere to the following:

   a. The actuarial value of the Standard Benefit Package can not exceed the actuarial value of the Blue Cross/Blue Shield Standard Option under the Federal Employees Health Benefits program.

   b. The Basic Benefit Package must contain higher cost sharing and/or fewer categories of benefits.

   c. Both benefit packages must include a full range of medically appropriate treatments and preventive services.

2. Categories:

The following categories of benefits are to be included in the benefits package:

a. Inpatient and outpatient care.
b. Emergency, including appropriate transport services.
c. Clinical preventive services, including services for high risk populations, immunizations, tests or clinician visits.
d. Mental Illness and Substance Abuse.
e. Family planning and services for pregnant women.
f. Prescription drugs and biologicals.
g. Hospice Care.
h. Home health care.
i. Outpatient laboratory, radiology and diagnostic.
j. Outpatient rehabilitation services.
k. Vision care, hearing aids and dental care for individuals under 22 years of age.
l. Patient care costs associated with investigational treatments that are part of approved clinical trial.

3. Priorities:

Within the constraints of the actuarial limits set in this act, Congress directs the Commission to adhere to the following priorities:

a. Parity for mental health and substance abuse services, which shall consist of a broad array of mental health and rehabilitation services managed to ensure access to medically necessary, and psychologically necessary treatment and to encourage the use of outpatient treatments to the greatest extent feasible.

b. Consideration for needs of children and vulnerable populations, including rural and underserved persons.

c. Improving the health of Americans through prevention.

4. Medically Necessary or Appropriate

A Qualified Health Plan shall provide for coverage of the categories of benefits described in this section for treatment and diagnostic procedures that are medically necessary or appropriate.

An item or service is "medically necessary or appropriate" if, consistent with prevailing medical standards, it is;

a. For treatment of a medical condition.

b. Safe and effective (i.e., there is sufficient evidence to demonstrate that the item can reasonably be expected to produce the intended health outcome or provide the intended information).

c. Medically appropriate for a specific patient (i.e., it can reasonably be expected to provide a clinically meaningful benefit if furnished in a setting commensurate with the patient's needs).

Criteria for determination of medically necessary or appropriate are set forth. QHPs shall make all coverage decisions under these criteria. The Commission can, in limited circumstances, issue interim coverage recommendations.

5. Cost-Sharing

The Commission shall also develop multiple cost sharing schedules which vary by delivery system organization. In making these determinations, the Commission will consult with expert groups for appropriate schedules for covered services. This clarification is subject to approval by Congress under expedited procedures.

6. Limitations

The Commission is prohibited from specifying provider types or specific procedures in the benefit packages.

7. Additional Commission duties related to defining the basic and standard benefits packages:

a. Develop interim coverage decisions in limited circumstances.

b. Design the basic and standard benefits packages to prevent adverse risk selection when combined with the risk adjustments called for in the bill.

c. May not specify provider types when clarifying covered benefits.

d. May not specify particular procedures or treatments or classes thereof.

8. Consideration of Commission Recommendations

The Commission will have the authority to propose modifications to the benefits package (within the actuarial value ceiling described above) that would not go into effect unless approved by Congress under base-closing procedures. The Commission is responsible for any updates to the benefits packages after the first year and these updates are also subject to Congressional approval under expedited procedures.

II. Qualified Health Plans

A. Accountable Health Plans (AHPs)

1. Definition: a health plan that may be operated as a variety of delivery systems such as indemnity plans, preferred provider organizations, health maintenance organizations, or other delivery systems. An AHP is a health plan that is certified by the state as meeting insurance market reform standards, health plan standards, quality, reporting standards, and other standards.

2. Standards

The National Health Care Commission (described in Section XIV.) will establish standards for AHPs. In addition, AHPs:

a. Must meet insurance reforms described in (I., C.).

b. May not engage in marketing or other practices intended to discourage and/or limit the issuance to eligible individuals on the basis of health condition, industry, geographic area or other risk factors.

c. Must make a health plan available throughout the entire HCCA area in which it is offered.

d. Must demonstrate its ability to make available and accessible to each potential enrollee in the area the full range of benefits required under the standard and basic benefit packages, when medically necessary and promptly.

e. Must provide for the application of coverage standards (for

benefits) which are consistent with the coverage standards issued by the Commission and disclosed to plan enrollees.

f. Must not accept enrollment of an individual who is currently enrolled in another AHP.

g. Must make available to nonparticipating providers the criteria used in selecting those providers that are permitted to participate in the plan.

h. Must comply with federal information requirements.

i. Must offer the standard and basic benefit packages, but may also offer benefits in addition to these packages, if such additional benefits are offered and priced separately from the standard and basic benefit packages.

j. Must comply with a system of binding arbitration for coverage disputes.

B. Employer-Sponsored (risk-bearing) Plans

1. Definition: a group health plan that may be operated as a network plan or an indemnity plan for which the employer retains all or a portion of the insurance risk, commonly referred to as self-insured.

2. Standards:

a. Employer sponsored plans must meet all the standards for AHPs and insurance market reforms, except they are not required to take all applicants, and the population served and area covered is defined by such an employer's employee population.

b. Financial solvency, reserve, and guarantee fund standards will be established by the Secretary of the Department of Labor (DoL) consistent with the applicable rules under Part 4 of Title I of ERISA.

c. The Secretary of DoL may take corrective actions to terminate or disqualify an employer-sponsored plan that does not meet the above standards.

d. The Secretary of DoL is appointed as trustee for insolvent employer-sponsored health plans.

C. **Qualified Association Plans (QAPs)**

1. Definition: Association health plans that have been in existence for three years prior to the date of enactment.

2. Standards:

   a. Must meet all standards for AHPs with the following exceptions:

      i. Special solvency requirements will be established by DoL for QAPs.

      ii. Must only take any member in their designated association.

3. Requirements for Sponsoring Entity (Association)

   a. Must be organized and maintained in good faith.

   b. Must have appropriate by-laws that specifically state the purpose, as a trade association, industry association, professional association, chamber of commerce, religious organization, or public entity association.

   c. Must have been established and maintained for substantial purposes other than to provide the health care required under this section.

   d. Must be, and have been, in operation (together with its immediate predecessor, if any) for a continuous period of not less than 3 years.

   e. Must receive the active support of its membership.

4. Treatment of Multiple Employer Welfare Arrangements (MEWAs)

   a. In general, upon enactment, a MEWA will meet the standards to become either a QAP or a certified purchasing group.

   b. Any MEWA that has been in effect for not less than 18 months upon enactment and with respect to which there is application with the domicile state for certification as a QAP, shall be treated for purposes of this subtitle as a Qualified Health Plan (if such

plan otherwise meets the requirements of this Act);

c. However, MEWAs will not be able to continue to operate if the domicile state can demonstrate that --

i. the sponsor has made fraudulent or material misrepresentation(s) in the application;

ii. the plan that is the subject of the application, on its face, fails to meet the requirements for a complete application; or

iii. a financial impairment exists with respect to the applicant that is sufficient to demonstrate the applicant's inability to continue its operations.

5. Treatment of Rural Electric Cooperatives (RECs) and Rural Telephone Cooperative Associations (RTCs)

RECs and RTCs can continue to exist if they meet the same standards as QAPs; or if they are certified by the state as a purchasing group.

D. **Multi-Employer (Taft-Hartley) Plans**

Taft-Hartley plans must meet the same requirements as large employers. (See Section III.B. below)

E. **Public Programs**

Existing public programs like Medicare, Medicaid, Department of Defense health programs, Department of Veterans Affairs health programs and Indian Health Service programs are considered to be Qualified Health Plans for the purposes of this section.

F. **Pre-emption of Certain State Laws regulating Insurance Plans**

The following state laws relating to health plans are preempted for any QHP:

1. State laws that restrict plans from:

a. limiting the number and type of providers who participate in a plan;

b. requiring enrollees to obtain health services from participating providers;

c. requiring enrollees to obtain referral for treatment by a specialist or health institution;

d. establishing different payment rates for participating providers;

e. creating incentives to encourage the use of participating providers;

2. State corporate practice of medicine laws;

3. State mandated benefit laws.

G. **Advance Directives**

1. Right to Self-Determination

a. Each Qualified Health Plan must notify enrollees of their rights to self-determination in health care decision-making and of the plan's policy regarding advance directives. Plans must maintain procedures to require that the existence and content of an advance directive is recorded in the patient's chart (written or electronic) and provide for a mechanism to notify all appropriate health care providers of the information.

b. Plans must provide for educational activities for patients and providers and must have a functioning process to provide for communication between the patient and the appropriate health care provider regarding all aspects of the patient's care, including obtaining informed consent, patient prognosis and treatment decisions, and the formulation of advance directives. Discussions of prognosis and treatment alternatives should occur at the time of diagnosis, prior to treatment and whenever there is a significant change of status which affects diagnosis, prognosis and treatment.

c. In order to receive Medicare or Medicaid reimbursement for particular procedure codes to be determined by the Secretary of HHS, claims forms (written or electronic) must include the physician's certification indicating that the patient discussed with the physician the diagnosis, prognosis and treatment options and that the patient's questions were answered.

2. Decisions by Surrogates

In the event that a state does not have a law on surrogate decision-maker for health care decisions, a federal health care surrogate standard shall apply. This standard is:

a. A surrogate may make a health-care decision for a patient who is an adult or emancipated minor if the patient has been determined by the primary physician to lack capacity and no agent or guardian has been appointed or the agent or guardian is not reasonably available.

b. An adult or emancipated minor may designate any individual to act as surrogate by personally informing the supervising health-care provider or specifying it in a health care power of attorney. In the absence of a designation, or if the designee is not reasonably available, any member of the following classes of the patient's family who is reasonably available, in descending order of priority, may act as surrogate:

   i. the spouse, unless legally separated;

   ii. an adult child;

   iii. a parent; or

   iv. an adult brother or sister.

c. If none of these individuals are reasonably available, an adult who has exhibited special care and concern for the patient, who is familiar with the patient's personal values, and who is reasonably available may act as surrogate.

d. A surrogate shall communicate his or her assumption of authority as promptly as practicable to the specified members of the patient's family who can be readily contacted.

III. Large and Small Employer Responsibilities and Purchasing Groups

A. Small Employer Purchasers

1. Definition: employers with 100 or fewer full-time employees.

2. Responsibilities:

   a. May not be the sponsor of a risk-bearing plan, but if a member of

an eligible Association may join a QAP.

b. Must provide all employees (including part-time and seasonal) with information regarding all AHPs offered in the HCCA in which the employer is located.

c. If an employee resides in another HCCA, the employer must provide information regarding how to obtain information regarding AHPs available in that HCCA.

d. Small employers must make available to their employees a choice of at least three Qualified Health Plans either by joining a purchasing group or through independent brokers or insurance agents.

e. Small employers who contribute toward coverage must pay to any Qualified Health Plan selected by the employee an amount equal to the contribution they would make on the employee's behalf to the health plan selected by the employer.

f. Payroll Deduction. If an employee requests, employer must arrange for payroll deduction to pay the premium amount due, less any employer contribution, to the plan or purchasing group of the employee's choice. However, if the employee selects a plan other than those offered by the employer, the administrative cost of making such a payroll deduction may be charged to the employee.

B. Large Employer Purchasers

1. Definition: employers with more than 100 full-time employees.

2. Responsibilities:

a. All large employers must offer their employees a choice of at least three QHPs, one of which must be a point-of-service option and one of which must offer a basic benefits package. A large employer may comply with this subsection by offering QHPs provided by a single entity. Large employers may also meet this obligation, in part, by making available to their employees the choice of a Qualified Association Plan (see below).

b. Large employers are ineligible to join the small employer and individual purchasing groups or to purchase insurance at the community rate either through a broker, independent agent,

purchasing cooperative, or public enrollment office.

c. Employees of large employers are also ineligible to purchase insurance at the community rate either through a broker, independent agent, purchasing cooperative, or public enrollment office.

d. All large employer purchasers are regulated by the DoL and remain subject to ERISA.

e. If an employer contributes to its employee's health coverage, it must provide coverage as of the first day of the month in which an employee becomes eligible. Once terminated, coverage continues through the end of the month of termination.

f. COBRA. An individual whose employment has been terminated by a large employer must elect within 30 days of the termination to either remain in the plan provided by the employer for a period not to exceed 12 months, or until the individual is reemployed, whichever is less.

g. Selection of Plan by Majority of employees. Each employer shall make selection of health plans on an annual basis. Employers, who are not contributing to coverage, shall comply with a selection made by more than 50% of employees.

C. Individual and Small Employer Purchasing Groups

1. These purchasing groups shall be chartered under state law.

2. Membership in these purchasing groups will be voluntary and limited to employers and employees of businesses with 100 or fewer employees, and to all other non-Medicaid U.S. citizens or legal residents not employed by a large employer who live in the HCCA area.

3. Nothing in the Act shall be construed to require any individual or small employer to purchase exclusively through a purchasing group.

4. Nothing in the Act requires the establishment of a purchasing group nor prohibits the establishment of a purchasing group in an area.

5. Nothing in the Act shall be construed from preventing a purchasing group from being the purchasing group for more than one HCCA.

6. Nothing shall be construed to prevent a state from establishing or designating more than one purchasing group in a HCCA.

7. Purchasing groups are permitted to contract selectively with Qualified Health Plans. Purchasing groups are permitted to negotiate a price lower than the community rate, if so, that price becomes the plan's new community rate. Nothing in this act shall be construed to prevent a purchasing group from negotiating prices on administrative fees or items outside the basic and standard benefits packages which may be unique to the purchasing group.

D. Allowing Access to Federal Employee Health Benefit Program

Any plan under the Federal Employee Health Benefit plan offered to federal employees in a HCCA must be available for purchase by individual and small group purchasers in that area. Non-federal employee purchasers shall pay a premium amount based on the local community rate for that plan, and shall not be a part of the FEHB insurance pool. Plans offered nationally through FEHB shall not be required to be open to non-federal employee enrollment.

IV. Nondiscrimination provisions that apply to all employers:

A. General Rules

Employers that contribute to the purchase of any employee's health care coverage may not discriminate against any employee based on the employee's income. Employers that contribute to the purchase of any full-time employee's health care coverage must make an equal dollar contribution to all full-time employees choosing to purchase health care coverage offered by such employer. In addition, employers that contribute to the purchase of any part-time employee's health care coverage must make a proratated equal dollar contribution to all part-time employees choosing to purchase health care coverage offered by such employer.

1. A large employer that otherwise contributes shall not be required to offer an equal dollar contribution to an employee or "cash out" an employee that does not choose to purchase health care coverage offered by such employer.

2. For purposes of part-time employees, a dollar contribution will constitute an equal dollar contribution if the employer makes a dollar contribution proportionate to the number of hours worked by the part-time employee.

B. **Special Rule for Small Employers**

1. To the extent a small employer contributes to an employee's health care coverage, the employer cannot discriminate against an employee that chooses to purchase health care coverage from other than such small employer.

2. In no event shall a small employer be required to "cash out" an employee who does not choose to purchase health care coverage through the employer. For example, if a small employer makes a contribution on behalf of a full-time employee that chooses a plan the employer offers, it must also make a contribution to a full-time employee that chooses a Qualified Health Plan not offered by the employer.

3. Small employers may charge a reasonable fee to cover their administrative costs associated with withholding and remitting employee health insurance premiums of employees not opting for the health care coverage offered by the small employer.

C. **Penalties**

To the extent an employer does not comply with these nondiscrimination rules, a penalty will be assessed for the period of time the employer is in noncompliance. Such penalty will be equal to $100 for each day, or part thereof, of such period. (See Section 4980B of the Internal Revenue Code for analogous rules).

D. **Definitions**

1. A full-time employee is defined as an individual who is employed for an average of 30 or more hours per week.

2. A part-time employee is defined as an individual who is employed for an average of at least 10 hours per week, but less than 30 hours per week.

3. An individual does not qualify as a full-time or part-time employee until the individual has been employed for six months (i.e., seasonal employees are not treated as part-time employees).

E. **Exemption for Collectively Bargained Plans**

Single-employer and multi-employer bona fide collectively bargained plans are exempt from these nondiscrimination rules.

V. Assistance to Individuals and Families for the General Purchase of Insurance

A. **Eligibility:**

Individuals and/or families not otherwise eligible for Medicare or Medicaid, whose income is less than 240% of the federal poverty level will be eligible for a Voucher for the purchase of a Qualified Health Plan.

B. **Amount of Voucher**

1. For individuals and families with incomes less than 100% of poverty the voucher will be equal to 100% of the average premium of the lowest 2/3 of Qualified Health Plans offered in the HCCA in which they reside or work.

2. For individuals and families with income above 100% of the federal poverty level, the Voucher amount will be decreased on a sliding scale basis to 240% of the federal poverty level.

C. **Phase-in Schedule for Vouchers**

Vouchers will be phased-in at the beginning of each year under the following schedule:

Calendar Year	Percentage of Poverty
1997	90%
1998	120%
1999	150%
2000	180%
2001	240%

D. **Administration of Vouchers**

1. The Secretary of HHS will establish a mechanism for determining eligibility for vouchers, for distributing application forms, and to the extent practicable, for allowing enrollment in a

Qualified Health Plan at the time of application for subsidy.

2. The Secretary may provide for administration of Vouchers through an appropriate State agency.

VI. Assistance to Individuals and Families -- Expanded Tax Deductibility (Described in Section XIII.,B.)

VII. Expanding Access for Underserved Populations

A. Community-Based Primary Care Grant Program

1. Three grant programs would be established to promote community health plans and practice networks.

   a. The HHS Secretary will establish a program to administer grants to the states for the purpose of creating or enhancing community-based primary care entities that provide services to low-income or medically underserved populations. This provision is designed to complement the existing federal Community and Migrant Health Center programs by making flexible funding available to local public health departments, rural hospitals, and other public and private community care entities.

   b. The Secretary of HHS may make grants to and enter into contracts with consortia of public and private health care providers for the development of qualified community health plans and practice networks. The Secretary will give preference to plans and networks with three or more categories of providers such as EACH/RPCHs, MAFs and other rural hospitals, migrant health centers, community health centers, homeless health services providers, public housing providers, family planning clinics, Indian health programs, maternal and child health providers, federally qualified health centers and rural health clinics, state and local health department programs and health professionals and institutions providing services in one or more Health Professional Shortage Areas (HPSAs) or to medically underserved populations.

   c. Loans and loan guarantees for capital costs would be authorized

for the development of qualified community health plans or practice networks.

B. Enhanced Assistance for Federally Qualified Health Centers

1. Expanded resources will be provided for the Federally Qualified Health Centers;

2. This provision is intended to complement the state-based community primary care grant program described above. Both provisions are aimed at addressing the shrinking availability of primary health care services in the country's rural and inner-city communities.

C. Tax Incentives for Practice in Rural, Frontier, and Urban Underserved Areas (As described in Section XIII., D.)

D. Development of Networks of Care in Rural and Frontier Areas

1. The HHS Secretary is authorized to waive certain Medicare and Medicaid requirements for demonstration projects to operate rural health networks. Public and private entities may apply for such waivers. The Secretary may award grants to assist organizations in rural networks planning.

2. The Secretary will conduct a study on the benefits of developing a supplemental benefit package and making available premiums that will improve access to health services in rural areas.

E. Grant Program for Low Interest loans for Capital Improvement in Rural and Underserved Areas

Loans and loan guarantees for capital costs would be authorized for the development of qualified community health plans or practice networks.

F. Office of the Assistant Secretary for Rural Health

Under this provision, the position of Director of the Office of Rural Health would be elevated to the position of the Assistant Secretary for Rural Health. The mission of the office would be expanded to include advising on how health care reform could impact rural areas.

G. Rural and Frontier Emergency Care

A rural emergency medical services program is established to improve emergency medical services (EMS) operating in rural and frontier communities. This program will:

1. Offer a matching grant program for improving state EMS services. These grants will encourage better training for health professionals and provide necessary technical assistance to public and private entities which provide emergency medical services;

2. Provide federal grants to states for telecommunications demonstration projects linking rural and urban health care facilities;

3. Establish an Office of Emergency Medical Services to provide technical assistance to state EMS programs;

4. Federal grant support will also be provided to the states for the development of air transport systems to enhance access to emergency medical services.

H. Medicare Dependent Hospitals

1. Modify Payments to Medicare Dependent Hospitals in the following manner:

   a. base payments on a 36 month period beginning with the first day of the cost reporting period that begins on or after April 1, 1990;

   b. conform target amounts to extension of additional payments;

   c. clarify of updates; and,

   d. would extend Medicare-dependent hospital classification through 1998.

2. Would establish a demonstration project regarding payment to larger Medicare dependent hospitals.

I. EACH/RPCH Program Improvements and Extension to all States

1. Expands the EACH/RPCh program to all states.

2. Rural community hospitals meeting eligibility criteria may qualify as

Rural Emergency Access Community Hospitals (REACHs).

3. Current special reimbursement to small rural Medicare--dependent hospitals enacted in Omnibus Budget Reconciliation Act of 1989 is extended.

4. Modify provisions that relate to hospital inpatient services in a Rural Primary Care Hospital so that:

   a. a RPCH cannot have more than 6 beds;

   b. the RPCH cannot perform surgery or any service requiring general anesthesia (unless the risk of transferring the patient outweigh the benefits);

   c. the Secretary can terminate the RPCH designation if the average length of stay for the previous year exceeded 72 hours. In determining the average length of stay, cases which exceed 72 hours due to inclement weather or other emergency conditions are not included in the calculations;

   d. the GAO must submit a report determining if the revised RPCH criteria have resulted in RPCHs providing patient care beyond their abilities or have limited RPCHs' abilities to provide needed services.

5. Designates EACH hospitals so that:

   a. urban hospitals can be designated as EACHs and do not need to meet the 35 mile criteria, but do have to meet all the remaining criteria. Urban EACHs would still be subject to the Medicare Protective Payment System; and,

   b. hospitals located in adjoining states and otherwise eligible as EACHs and RPCHs can participate in a state's rural health network and these hospitals or facilities are permitted to receive grants.

6. Permit RPCHs to maintain swing beds in a Skilled Nursing Facility except that the number of swing beds may not exceed the total number of swing beds established at the time the facility applied for its RPCH designation. Beds in a distinct-part SNF do not count towards the total number of swing beds.

7. Extend the deadline for the development of prospective payment system for inpatient RPCH services to January 1, 1996.

8. Clarify that physician staffing criteria only apply to doctors of medicine and osteopathy.

9. Adopt technical amendments relating to Part A deductible, coinsurance and spell of illness.

10. The Department of Justice and Federal Trade Commission would be instructed to issue formal guidelines for EACH/RPCHs.

11. The Secretary would be permitted to designate an unlimited number of RPCHs in non-EACH states. The RPCHs must establish relationships with a full-service rural hospital that meet the same criteria as EACHs with the exception of the criteria that the EACH have 75 beds.

12. HHS would be required to conduct a pilot program that would allow RPCHs to admit patients on a limited DRG basis instead of using the 72-hour average length of stay criteria.

13. Codify the MAF requirements into Medicare, allowing Medicare to reimburse on a cost basis those facilities which meet the MAF requirements.

14. Develop a grant program for states that operate MAFs. The grant program would be modeled after the EACH/RPCH program.

J. Extends the Rural Health Transition Grant Program

Extends the program through FY 1998 with authorized appropriations of $30 million annually, FY 1993 - 1998. Reports from grantees would be required every 12 months. As of October 1, 1994, RPCHs are eligible for rural health transition grants.

K. Increases reimbursement to PAs and NPs under Medicare

1. Certified Nurse Practitioners and Physicians Assistants would be reimbursed at 85% of the RBRVS rate for services performed in all outpatient settings.

2. Under Medicare, certified Nurse Practitioners would be reimbursed at 65% of the RBRVS rate for assisting at surgery in urban areas.

3. States would be required to directly reimburse all certified Nurse Practitioners in a rural area under Medicaid. This expands the current

requirement that all states directly reimburse pediatric and family Nurse Practitioners, which gives states the option of directly reimbursing other types of NPs.

L. Telemedicine and Related Telecommunications Technology

1. Coordinates various federal grant programs which fund telemedicine and related telecommunications demonstrations and grant programs. This provision establishes a federal interagency task force, coordinated and chaired by the Department of Health and Human Services, would be established to oversee telemedicine and other telecommunications demonstration projects already underway.

2. A grant program would be established to fund telemedicine and related telecommunications technology in rural areas. The program would be administered through the Assistant Secretary for Rural Health. Applicants for the grant would be rural health care providers such as rural referral centers, rural health clinics, community health centers, migrant health centers, area health and education centers, local health departments and public hospitals.

M. National Health Service Corps

1. Fully funds the National Health Service Corps program and require that at least 20% of those in the Scholarship and Loan Repayment Program be nurses and physicians assistants

2. Reauthorize the Community Scholarship Program. In addition, the criteria for selecting students should be modified and a 15% administration fee for those agencies administering the scholarships should be established.

N. Indian Health Reform Amendments

1. Indian Health Service remains as a provider of health care for the Indian population.

2. Reaffirms current federal policy of guaranteeing that Indian Tribes should be eligible to apply for all appropriated funds and grants created under health reform legislation, at levels not less than any other qualified entities. This provision is simply a reaffirmation of current Federal policy.

3. Requires the Assistant Secretary for Indian Health to establish a new formula for the distribution to tribes of all new funds that become available for health care initiatives and programs under health reform. This formula would consider differences in local resources, status of health, socioeconomic status of Tribal people, and facilities/equipment/staff that are available.

4. Retains Indian eligibility under current law for additional benefits. Under this provision, whatever comprehensive benefits one accrues through health reform legislation, Indians would not lose any current benefits. Such benefits include all supplemental benefits, such as environmental health, mental health benefits, and alcohol abuse treatment.

O. Transitional Requirements for Plans Serving Special Needs Populations

1. Nondiscrimination Service Area Standards
Health plans must not discriminate in the drawing of services area boundaries on the basis of race, ethnicity, socioeconomic status, age, or anticipated need for health services.

2. Special Access Standards
Plans must meet special access standards that take into account the special needs and circumstances of urban and rural underserved areas. The Secretary would be required to establish access standards for enrollees living in medically underserved areas that take into account the following indicators:

   a. Accessibility of primary care services based on measures such as the ratio of primary care providers to expected enrollees;
   b. Accessibility of other services, based on measures such as travel time;
   c. Accessibility of health plans services for individuals with limited ability to speak the English language, and for population with similar needs.

3. Reporting Requirements
Health plans must report on key indicators of access, quality and service in a manner that provides separate information and monitoring for those in medically underserved areas.

4. Designation of Underserved Communities and Populations
The Secretary would annually designate underserved areas and populations as either of the following areas:

   a. Areas with a shortage of personal health services as designated

under section 332(a)(3) or 1302(7) of the Public Health Service Act;

b. Health Professional Shortage Areas as described in section 332(a)(1)(a) of the PHS Act;

c. High impact areas as described in section 329(a)(3) of the PHS Act; or

d. an area which includes a population group which the Secretary determines as a health manpower shortage area under Section 332(a)(1)(B) of the PHS Act.

5. Certification of Essential Community Providers

Any public or non-profit private entity furnishing services in a designated medically underserved community or population may apply to the Secretary for certification as an essential community provider. In order to be certified, the entity:

a. Must be a public or non profit private entity;

b. Must be capable of providing for a full range of primary health care services that are available and accessible promptly, as appropriate and in a manner which assures continuity;

c. Have organization arrangements for quality assurance programs and maintaining patient record confidentiality;

d. Demonstrate financial responsibility;

e. Accept all patients notwithstanding their ability to pay;

f. Make every effort to collect appropriate reimbursement from Medicare, Medicaid and third party payers;

g. Establish a sliding-scale fee schedule based on ability to pay for services;

h. Reviews annually its catchment area;

i. Where appropriate, provides access to patients with limited english-speaking ability;

j. Meets the requirements of section 1861(z) of the Social Security Act, compiles appropriate statistical and other information.

6. Obligation to Offer Contracts for Primary Care Services

All health plans, including self-insured plans, would be required to offer a contract with a reasonable number as determined by the Secretary of certified essential community providers. Mandatory contracting would be in effect for the first five years after enactment.

7. Scope of Contracts

The contract between health plans shall:

a. Provide for primary health services that are included in the uniform benefit package, furnished on an outpatient basis and provided directly by the essential community provider.

b. Terms and conditions applied to the agreements shall be comparable to terms and conditions that apply to other providers furnishing comparable services to the health plan.

c. Payment will be based on Section 1876 of the Social Security Act.

8. Health Plan Obligation for Non-primary Care
Health plans must meet general access standards for non-primary care services to insure accessibility and availability of all covered and non-covered primary care services for all enrolled members. (Needs more definition.)

9. Access in Underserved Areas

The Office of Technology Assessment (OTA) will conduct a study on improving access in underserved areas.

P. Urban " Safety-Net" Hospitals

Establishes a revolving loan fund and grant program to fund capital improvements for publicly owned and operated "safety-net" hospitals.

Other Urban Hospitals

Demonstration for inaccessible other urban Hospitals to qualify as Sole Community Hospitals.

VIII. New Home and Community Based Long Term Care Program

A. General

Establishes a new capped program in the Social Security Act to provide home-and community-based services for older Americans and individuals with disabilities. The program is administered by the States with federal matching payments for services provided. Total funding is capped, and there is no individual entitlement to services under this program.

B. Eligibility

The Secretary will issue regulation establishing uniform eligibility criteria and assessment protocols. In order to receive benefits under the program, an individual must be determined eligible, must undergo

a standardized assessment and have a individualized plan of care developed. To be eligible, an individual must be in one of the following categories. The first three categories apply to individuals of all ages; the final category applies only to children under age six.

1. Requires hands-on or stand-by personal assistance supervision or cues in three or more of five activities of daily living: eating dressing bathing, toileting, and transferring in and out of bed.

2. Presents evidence of severe cognitive or mental impairment.

3. Has severe or profound mental retardation.

4. Is under age six and would otherwise require hospital or institutional care for a severe disability or chronic medical condition.

C. Covered Services

1. At a minimum, a state's array of services must include personal assistance (both agency administered and consumer directed) for every eligible category of participant. Services may include, but are not limited to: case management, homemaker and chore assistance, home modifications, respite services, assistive technology, adult day services, habilitation and rehabilitation, supported employment, and home health services.

2. Services may be delivered in a home, a range of community residential arrangements, or outside the home. Services may not be provided in licensed nursing homes or intermediate care facilities for the mentally retarded.

D. Cost Sharing

Eligible individuals with incomes over 150% of the federal poverty level pay co-insurance to cover a portion of the cost of all services they receive according to a sliding scale. Persons with incomes between 150% and 200% of the federal poverty level pay 10% of the cost of care; between 200% and 250% of poverty 20% co-insurance, and persons with income over 250% of poverty pay a 25% co-insurance.

E. State Administration

Each state must have an approved plan, which specifies: administering agency or agencies; services to be covered, and how the needs of all types of eligible individuals will be met; provide a plan for making eligibility determinations: provide information on how the state will develop care plans, coordinate services, reimburse providers and plans, administer vouchers or cash payments, license or certify providers. In addition, the state must develop a system of determining allocation of resources and how the new program with be integrated with existing long-term care programs, and must assure that low-income persons in the program is at least equal to the proportion of low-income persons in the state's population.

F. Quality Assurance

States are responsible for developing comprehensive quality assurance programs that monitor health and safety of participants as well as assure that services are of the highest quality. States must develop, for federal approval, quality assurance systems that include consumer satisfaction surveys. In addition, consumer advisory groups are expected to play a strong role in assuring and enhancing quality.

G. Federal Matching Payments to States

A federal matching payment will be made to states based on the current Medicaid match rate plus 28 percentage points. Federal matching percentages can be no less than 78 percent and no more than 95 percent. No federal matching payments will be made once the cap is reached.

H. Funding, Allotments to States

For federal Fiscal years 1996-2002 - No federal funds allocated.

PART TWO - COST CONTAINMENT & CONSUMER PROTECTION

A. High Cost Plan Assessment (described in Section XIII., A.)

B. Medical Liability Reform

1. Alternative Dispute Resolution

a. No health care malpractice action may be brought in court until final

resolution of the claim under an alternative dispute resolution (ADR) method adopted by the state from models developed by the Secretary of HHS, or developed by the state and approved by the Secretary of HHS.

b. If the party initiating court action following the ADR receives a worse result with respect to liability or a level of damages 33 1/3% below that awarded in the ADR, that party must pay the costs and attorneys fees of the other party incurred subsequent to the ADR.

2. Damages

Non-economic damages awarded to a plaintiff in a health care malpractice claim or action may not exceed $250,000, indexed for inflation.

3. Several Liability

The liability of each defendant in a health care malpractice action for non-economic and punitive damages will be based on each defendant's proportion of responsibility for the claimant's harm.

4. Punitive Damages

Seventy-five percent of punitive damage awards will be paid to the state in which the action is brought and such funds will be used for provider licensing, disciplinary activities and quality assurance programs.

5. Statute of Repose

A twenty year statute of repose will be applied to health care malpractice actions.

6. Fee Reform

Lawyers may not charge contingency fees greater than 33 1/3% of the first $150,000 of the award in a health care malpractice action and 25% of amounts in excess of $150,000. Calculation of permissible contingency fees is based on after tax amounts.

7. Limited Preemption

State laws that have higher limits on attorneys fees and non-economic damages are preempted. State laws that provide for longer statutes of repose are preempted. Does not preempt those laws with lower limits on attorneys fees and non-economic damages are preempted. Does not preempt state laws with shorter statutes of repose.

C. Administrative Simplification and Paperwork Reduction

Implements a national health information network to reduce the burden of administrative complexity, paper work, and cost on the health care system; to provide the information on cost and quality necessary for competition in health care; and to provide information tools that allow improved fraud detection, outcomes research, and quality of care.

1. National Health Information Network

   Requires the Secretary of HHS to implement a national health information network by adopting standards for:

   a. representing the content and format of health information in both paper and electronic forms,

   b. transmitting information electronically,

   c. conducting transactions using this information,

   d. certifying public or private entities to perform the intermediary functions which implement the network,

   e. monitoring performance to assure compliance,

   f. establishing procedures for adding codes to previously adopted standards,

   g. making changes to previously adopted standards, and

   h. developing, testing, and adopting new standards.

2. Health Information Advisory Commission

   In carrying out duties under this part, the Secretary would consult with an Advisory Commission consisting of 15 members from the private sector with expertise and practical experience in developing and applying health information and networking standards. The members would be appointed by the President and serve staggered 5 year terms, and would include providers and consumers.

3. Requirements for Qualified Health Plans and Health Care Providers

All Qualified Health Plans, including Federal and State plans, and all health care providers would be required to comply with federal standards for formatting information and electronic transactions.

The Secretary may require transactions to be consistent with the goal of reducing administrative costs. In addition, certain standard data must be made available electronically on the health information network to authorized inquiries. Other requirements for electronic information, such as quality related information, may be specified in other parts of the law and would be put through the same standards setting procedure before becoming required.

4. Accessing Health Information

   a. The Secretary would establish technical standards for requesting standard health information from participants in the health information network which assure that a request for health information is authorized under federal privacy provisions.

   b. The Secretary would establish standards for the appropriate release of health information to researchers and government agencies, including public health agencies. The Secretary would establish standards for the electronic identification of a request as one which comes from a person authorized to receive health information under federal privacy provisions.

5. Effective Date

   A timetable of effective dates would be included which would specify when each requirement would take effect relative to the date of enactment. In general, the Secretary would adopt existing standards within 9 months of enactment and more time is given for standards which must be developed. At least 12 months grace period is allowed after any standard is adopted before use of that standard becomes required.

D. Quality Assurance

The goal of health reform is to ensure that Americans have access to health care plans that compete on the basis of price and quality. Assessing quality requires reliable and comparable information on the outcomes and effectiveness of services provided by plans. Under this subtitle, Qualified Health Plans are required to annually report data on the quality of their services to the Secretary of HHS in a format prescribed under the National Health Information Network. The Secretary may determine the manner in

which these data are provided to certifying authorities in states. This title also provides direction to the Secretary to improve and expand the capability of HHS to support and encourage research and evaluation of medical outcomes.

Standards and Measurements of Quality

The Secretary, in consultation with relevant private entities, will develop quality standards with which all Qualified Health Plans must comply. These standards are designed to improve the data available upon which to assess quality and the processes by which quality care is continuously improved.

The Secretary will study the capabilities of entities within its jurisdiction to accomplish these goals including:

1. setting priorities for strengthening the medical research base;

2. supporting research and evaluation on medical effectiveness through technology assessment, consensus development, outcomes research and the use of practice guidelines;

3. conducting effectiveness trials in collaboration with medical specialty societies, medical educators and qualified health plans;

4. maintaining a clearinghouse and other registries on clinical trials and outcomes research data;

5. assuring the systematic evaluation of existing and new treatments, and diagnostic technologies in an effort to upgrade the knowledge base for clinical decision making and policy choice;

6. designing an interactive, computerized dissemination system of information on outcomes research, practice guidelines, and other information for providers.

E. Anti-fraud and Abuse Control Program

This subtitle establishes a stronger, better coordinated federal effort to combat fraud and abuse in our health care system. It expands criminal and civil penalties for health care fraud to provide a stronger deterrent to the billing of fraudulent claims and to eliminate waste in our health care system resulting from such practices. It also seeks to deter fraudulent utilization of health care services. It would:

1. Require the HHS Secretary and Attorney General to jointly establish and coordinate a national health care fraud program to combat fraud

and abuse in government and Qualified Health Plans;

2. Finance the anti-fraud efforts by setting up an Anti-Fraud and Abuse Trust Fund. Monies from penalties, fines, and damages assessed for health care fraud are dedicated to the Trust Fund to pay for the anti-fraud efforts;

3. Increase and extend Medicare and Medicaid civil money and criminal penalties for fraud to all health care programs;

4. Bar providers convicted of health care fraud felonies from participating in the Medicare program;

5. Require HHS to publish the names of providers and suppliers who have had final adverse actions taken against them for health care fraud; and,

6. Establish a new health care fraud statute patterned after existing mail and wire fraud statutes under Title XXIII of the Criminal Code and allows for criminal forfeiture of proceeds.

X. REFORM OF EXISTING PUBLIC PROGRAMS

A. **Medicaid** (Some would like to integrate Medicaid faster if it did not adversely affect the cost of health care reform.)

1. Integration of Medicaid beneficiaries into Qualified Health Plans

a. The Secretary shall make recommendations on the integration of AFDC and non-cash recipients into the community-rated pool and into Qualified Health Plans. The Secretary's recommendations shall address:

i. the impact on private health insurance premiums,

ii. the administration of subsidies,

iii. the adequacy of services for Medicaid recipients and the need for and structure of wrap around services.

2. New State Option for Medicaid Coverage in Qualified Health Plans

States may give their AFDC and non-cash eligible beneficiaries

(excluding medically needy) the option to receive medical assistance through enrollment in a Qualified Health Plan offered in a local HCCA instead of through the Medicaid plan.

a. The state may not restrict an individual's choice of plan and is not required to pay more than the applicable dollar limit for the HCCA area.

b. The number of individuals electing to enroll in a Qualified Health Plan is limited to a fifteen percent of the eligible population in each of the first three years, and ten percent in each year thereafter.

3. Limitation on Certain Federal Medicaid Payments

Federal financial participation for acute medical services, including expenditures for payments to Qualified Health Plans, is subject to an annual federal payment cap.

a. The cap is determined by multiplying a per capita limit (defined below) by the average number of Medicaid categorical individuals entitled to receive medical assistance in the state plan.

b. The per-capita limit for fiscal year 1996 is equal to 118% of the base per capita funding amount (determined by dividing the total expenditures made for medical assistance furnished in 1994 by the average total number of Medicaid categorical individuals for that year).

c. After 1996, the per-capita limit is equal to the per-capita funding amount determined for the previous fiscal year increased by 6 percent for fiscal years 1997 through 2000, and 5 percent for fiscal year 2001 and beyond.

d. Expenditures for which no federal financial participation was provided and disproportionate share payments are excluded from this calculation.

e. States are required to continue to make eligible for medical assistance any class category of individuals that were eligible for assistance in fiscal year 1994.

4. State Flexibility to Contract for Coordinated Care Services

a. States have the option, to establish a program under Medicaid

program to allow states to enter into contracts with at-risk primary care case management (PCCM) providers.

b. An at-risk PCCM provider must be a physician, group of physicians, a federally qualified health center, a rural health clinic or other entity having other arrangements with physicians operating under contract with a state to provide services under a primary care case management program.

c. Qualified risk contracting entities must:

i. meet federal organizational requirements;

ii. guarantee enrolled access; and,

iii. have a written contract with the state agency that includes:

(a). an experienced-based payment methodology;

(b). premiums that do not discriminate among eligible individuals based on health status;

(c). requirements for health care services; and,

(d). detailed specification of the responsibilities of the contracting entity and the state for providing for, or arranging for, health care services.

d. Meet federal standards for internal quality assurance.

e. Enter into written provider participation agreements with essential community providers;

1. States are required to contract directly with essential community providers, or at the election of the ECP, each risk contracting entity may enter into agreement to make payments to the essential community provider for services.

2. Essential community providers include:

a. Federally Qualified Health Centers,

b. Public Housing Providers,

c. Family Planning Clinics,

d. AIDS providers under the Ryan White Act,

e. Maternal and Child Health Providers, and

f. Rural Health Clinics.

B. Medicare

1. Medicare remains a separate program and continues to be federally administered. Beneficiaries enrolled in Part B continue to pay a monthly premium. The statutorily defined Medicare benefits continue to be the Medicare benefit package in both fee-for-service and managed care.

2. Beneficiary opt-in to private qualified health plans.

   a. Medicare beneficiaries may opt into a qualified health plan in their HCCA.

   b. For individuals choosing an AHP, Medicare will pay the federal contribution calculated for Medicare risk contracts. Individuals are responsible for paying the difference between the premium charged and the federal contribution.

   c. During the annual enrollment period, Medicare-eligibles may choose a new plan through their employer/purchasing cooperative or they may return to the traditional Medicare program.

3. Medicare Select

   a. The Medicare Select program would become a permanent option in all States.

   b. Medicare Select policies will be offered during Medicare's coordinated open enrollment period.

   c. Plans may not discriminate based on health status.

4. Medicare Risk Contract Program

   a. Medicare health plans must meet Qualified Health Plan standards and cover all Medicare benefits under a risk contract for a uniform monthly premium for a year.

b. Employers may sponsor Medicare health plans for former or current employees.

c. Cost contracts, SHMOs, etc. would continue as under current law. The 50/50 requirement is terminated at the point at which the Secretary determines that health plans have alternative quality assurance mechanisms in place that effectively provide sufficient quality safeguards. In the interim, the Secretary may grant waivers of the 50/50 requirement.

e. Medicare health plans will offer a standard benefit package comprised of the current Medicare benefits defined in statute or an alternative package, defined by the Secretary, covering identical services but with cost-sharing consistent with typical managed care practice and not to exceed the actuarial value of FFS.

f. Standardize supplemental benefits that risk contractors may offer in addition to Medicare benefits. In addition to the standardized policies, health plans may offer other supplemental policies. However, Medicare health plans must at least offer two supplements to be defined by the Secretary: one which would cover catastrophic costs (out-of-pocket limit) and other items traditionally covered in employer-sponsored plans, and one covering outpatient prescription drugs.

g. The current standardized Medigap plans would be changed so that Medigap may only pay up to one-half of the 20% part B coinsurance. Beneficiaries currently holding Medigap plans covering the entire 20% coinsurance would be exempt from this change as long as they renew their current insurance.

h. The Secretary shall define Medicare market areas which shall be consistent with the health care coverage areas defined by the non-Medicare population. For the Medicare program, the MSAs may cross state lines if the Secretary determines it is necessary to increase choices to Medicare beneficiaries. The federal contribution for a Medicare health plan will be the same throughout the Medicare market area.

i. The Secretary will administer a coordinated annual open enrollment period during which Medicare beneficiaries will choose from all plans (including Medigap insurers) offering products to Medicare beneficiaries. The Secretary may authorize any variations of participation in the enrollment process.

j. The Secretary of HHS will provide to all Medicare beneficiaries in a market area uniform materials for enrolling in health plans.

k. The federal contribution is calculated as the weighted average of fee-for-service per capita cost in the market area and the premiums submitted by Medicare health plans to the Secretary to provide Medicare benefits. The Secretary is authorized to adjust for heart disease, cancer, or stroke.

l. Beneficiaries pay the difference between the federal contribution and the total premium charged by the health plan they select. If the health plan's premium is less than the federal contribution, the beneficiary is entitled to a rebate that the plan may provide in cash or apply to supplementary coverage. The rebate would be treated as non-taxable income.

i. Beneficiaries eligible for Medicare prior to 1999 are grandfathered under these provisions and may always enroll in Medicare FFS (regardless of local costs) for the regular part B premium only.

ii. If the federal contribution is less than the FFS per capita cost in the market area and the beneficiary selects Medicare FFS, the beneficiary pays an additional premium to the Federal Government equal to the difference between the federal contribution and FFSPCC.

5. Administrative Simplification

The Secretary has authority to consolidate the functions of fiscal intermediaries and carriers. Provides for coordination of Medicare and supplemental insurance claims processing. Permits standardized, paperless process.

6. Study and Demonstration for Medicare Cost Containment

a. Requires ProPAC to study and make recommendations to Congress regarding ways to slow the rate of Medicare growth at the local market level. The study should include ways to set local expenditure targets and monitor success in controlling costs. Updates for payment rates under Parts A and B should be set to achieve local targeted expenditure levels, while rewarding efficient providers and/or markets.

b. A demonstration is authorized to evaluate Part A expenditures for hospital service and/or Part B expenditures in fee for service using provider-group or State-level volume performance

standards.

C. GRADUATE MEDICAL EDUCATION

[Under Discussion]

I. FINANCING

A. Financing Totals (Estimated Over 5 years; $ in Billions)

Savings

Medicare Savings	$70.1	
Medicaid Savings	$55.8	
Postal Service Retirement	$13.0	
SUBTOTAL SPENDING REDUCTIONS		$138.9

Revenues

High Cost Plan Premium Assessment	$30.0*	
Tobacco Tax ($1.00 increase)	$62.3	
HI State/Local	$ 7.6	
Income Relating Medicare Part B Premiums	$ 8.0	
SUBTOTAL REVENUES		$107.9
TOTAL FINANCING		$246.8

* Preliminary estimate based on available information

B. Descriptions of Medicare Savings

1. **Adjust Inpatient Capital Payments.** This proposal combines three inpatient payment adjustments to reflect more accurate base year data and cost projections. The first would reduce inpatient capital payments to hospitals excluded from Medicare's prospective payment system by 15%. The second would reduce PPS Federal capital payments by 7.31% and hospital-specific amount by 10.41% to reflect new data on the FY 89 capital cost per discharge and the increase in Medicare inpatient costs. The third piece would reduce payments for hospital inpatient capital with a 22.1% reduction to the updates of the capital rates.

2. **Revise Disproportionate Share Hospital Adjustment.** ThisAct eliminates the current disproportionate share hospital adjustment with a new voucher program to cover health care provided to those with out health insurance.

3. **Extend OBRA 93 Provision to Catch-up after the SNF Freeze Expires Included in OBRA 93.** OBRA 93 established a two-year freeze on update to the cost limits for skilled nursing facilities. A catch-up is allowed after the freeze expires on October 1, 1995. This Act eliminates the catch-up.

4. **Change the Medicare Volume Performance Standard to Real Growth GDP.** This Act substitutes the five-year average growth in real GDP

per-capita for this volume and intensity factor and the performance standard factor for physician's services.

5. **Establish Cumulative Growth Targets for Physician Services.** Under this Act, the Medical Volume Performance Standard for each category of physician services would be built on a designated base-year and updated annually for changes in beneficiary enrollment and inflation, but not for actual outlay growth above and below the target.

6. **Reduce the Medicare Fee Schedule Conversion Factor by 3% in 1995, Except Primary Care Services.** The conversion factor is a dollar amount that converts the fee schedule's relative value units into a payment amount for each physician service. This Act reduces the factor by 3% to account for excessively high targets.

7. **Extend OBRA-93 Provisions on Part B Premium Collections.** OBRA 93 established the Part B premium collections at 25% of program costs. This Act extends the collection of these premiums.

8. **Extend OBRA 93 Catch-up After the Home Health Freeze Expires.** OBRA 93 eliminated the inflation adjustment to the home health limits for two years. This Act eliminates the inflation catch-up currently allowed after the freeze expires on July 1, 1996.

9. **Extend OBRA 93 Medicare Secondary Payor Data Match with SSA and IRS.** OBRA 93 included an extension of the data match between HCFA, IRS and SSA to identify the primary payers for Medicare enrollees with health coverage in addition to Medicare.

10. **Increase Part B Deductible for Enrollees.** Increase the amount that enrollees must pay for services each year before the government shares responsibility for physician services. The deductible would be increased to $150 and indexed to the rate of growth.

11. **Reduce Hospital Market basket Index Update.** This proposal reduces the Hospital Market Basket Index Update by 2%. Currently Medicare changes the inpatient per-discharge standardized amount by a certain amount every year to reflect input costs changes in Congressional direction. OBRA 1993 reduced the Index in Fiscal Years 1994 through 1997. This proposal would reduce the updates by 2% for Fiscal Years 1997 through 2000.

C. **Medicaid Savings**

1. **Revise Disproportionate Share Hospital Adjustment.** This proposal eliminates the current disproportionate share hospital adjustment with the new voucher program to cover health care provided to those with out health insurance. Medicaid DSH payments are to be

eliminated in FY 1996 - 15%, FY 1997 - 25%, FY 1998 - 60% and 1999 - 100%

2. **Capitate the Federal Payments Made for Medicaid Acute Care Medical Services under Medicaid Program.** The per-capita federal financial participation growth rate for acute medical services under the Medicaid program would be capped at 6% for fiscal years 1997 through 2000 and at 5% for fiscal year 2001 and beyond.

D. Revenues

1. **Postal Service Retirement.** Require the U.S.P.S. to fund the U.S.P.S. Retirement System in the U.S.P.S. budget rather than the Federal Budget. This would free funds from the Federal budget.

2. **Tobacco Tax.** The proposal increases the tax on tobacco by ___ per thousand pounds ($1 per pack of 20 cigarettes). Described in Section XIII., G.)

3. **HI State and Local .** State and local jurisdictions can opt to pay the HI payroll tax for State and local workers hired before April 1, 1986. The proposal would extend the payroll tax to all remaining exempt State and local workers.

4. **Income Related Part B Premiums.** This proposal would charge high-income enrollees a premium up to 75% of program costs based on an enrolle's modified adjusted gross income.

XII. Fiscal Responsibility

Fail-Safe Mechanism

The bill establishes a Fail-Safe mechanism to ensure health care reform does not increase the deficit. Details are described below:

1. A Current Health Spending Baseline (CHSB) is established. The CHSB includes:

   a. Medicare Expenditures

   b. Medicaid Expenditures

   c. Health Related Tax Expenditures

      i. The employee exclusion of employer-provided health insurance premiums.

ii. Employer deduction for health insurance premiums.

iii. 7.5% floor for deduction of medical expenses.

2. A Health Reform Spending Estimate (HRSE) is established. The HRSE includes:

a. Everything included in the CHSB.

b. Deduction for purchase of Qualified Health Plans by all individuals.

c. Cigarette excise tax.

d. Vouchers for purchase of a Qualified Health Plan.

e. High-Cost Plan Assessment

3. In any year that the Director of OMB notifies Congress that HRSE will exceed the CHSB, the following automatic actions will occur to prevent deficit spending:

a. The voucher phase-in is delayed.

b. The assessment on high cost insurance plans is increased.

c. The expanded tax deduction phase-in is slowed down.

d. Out-of-pocket limits in the standard and basic benefit packages are increased.

e. Starting in the year 2004, an employer may no longer deduct and an employer may no longer exclude supplemental benefits provided to employees and contributed to by employers.

4. Congress may act on alternative recommendations made by the National Health Commission to avoid the actions listed above.

XIII. Tax Provisions

A. High Cost Plan Assessment

1. Beginning in 1996, an annual assessment will be imposed on High Cost Plans. High Cost Plans are those health care packages whose premiums (not including supplemental benefits, if any) exceed a certain dollar amount.

a. To determine whether a plan is a High Cost Plan, an insurer divides its plans into two categories:

i. those based on the basic package (Primary Basics), and

ii. those based on the standard package (Primary Standards).

b. It then determines which, if any, of either the Primary Basics or Primary Standards are priced such that they are in the top 40 percent of all such plans in the health care coverage area (HCCA).

c. Plans that fall within the lowest 25% of the geographically - adjusted plan premiums nationally are exempt. For purposes of determining whether a plan is exempt, the Primary Basic and Primary Standard plans are considered separately.

d. The geographically adjusted premium is calculated by adjusting each accountable health plan's premium for regional variations. Such adjustments shall include, but not be limited to, variations in the cost of living and demographics.

2. The assessment on a High Cost Plan is equal to 25% of the difference between the premium charged for the Primary Basic plus supplementals, if any, and the Primary Standard plus supplementals, if any, and a reference premium.

a. For purposes of determining the assessment on the Primary Basic plus supplementals, if any, the reference premium is the average of all Primary Basics in the HCCA.

b. For purposes of determining the assessment on the Primary Standard plus supplementals, if any, the reference premium is the average of all Primary Standards in the area.

3. The High Cost Plan Assessment also applies to self-insured plans. The tax will apply to the difference between the self-insured High Cost Plan's premium (including any supplementals) and the applicable reference premium for the HCCA. In calculating this tax, the high cost self-insured plan's premium will be the premium used for meeting the COBRA requirement. The Department of Treasury will be given authority to develop regulations implementing this provision.

B. Assistance to Individuals and Families -- Expanded Tax Deductibility

1. Self-employed individuals purchasing health insurance may take an above-the-line deduction for 100% of the cost of such insurance (i.e., not subject to the 7.5% floor), subject to a phase-in period. However, the deduction is limited to the cost of either a basic or standard benefits package. To the extent self-employed individuals purchase benefits

supplementing such packages, the cost of such supplemental benefits will be deductible as medical expenses under current law (i.e., subject to the 7.5% floor).

2. Individuals (other than self-employed) that purchase health insurance will be allowed an above-the-line deduction (i.e., not subject to the 7.5% floor) for 100% of the cost of either a basic or standard benefit package. To the extent an individual purchases benefits supplementing the packages, the cost of such supplemental benefits will be deductible as medical expenses under current law (i.e., subject to the 7.5% floor).

C. Employer-Provided Health Insurance

1. Employees may continue to exclude from gross income all employer-provided health insurance.

2. Employers may take a deduction for amounts contributed towards a standard benefits package, as well as all benefits supplementing such package, if any.

3. Employers may take a deduction for amounts contributed towards a basic benefits package. However, no deduction is permitted for any contributions made towards benefits supplementing the basic benefits package.

4. Fail-Safe option includes possible employer and employee cap on supplementals after 2004.

D. Tax Incentives for Practice in Rural, Frontier, and Urban Underserved Areas

1. Physicians practicing full-time and either newly certified or newly relocated to a rural, frontier, or urban Health Professional Shortage Areas (HPSA) are allowed a tax credit equal to $1,000 a month up to a total of $36,000. Tax credits will be prorated in direct relation to the time worked in the HPSA, up to a total of $36,000;

2. Nurse practitioners and physician assistants would be eligible for a similar credit equal to $500 per month;

3. In order to retain the full value of the credit, the physician, nurse practitioner or physician's assistant must practice continuously in the area for five years.

4. Loan repayments made on behalf on an individual as part of the National Health Service Corps Loan Repayment Program are excluded from taxable income of the individual;

5. The cost of annually purchased medical equipment, owned directly or indirectly, and used by a physician in a rural or frontier Health Professional Shortage Area (HPSA) can be immediately expensed, up to $32,500;

6. Interest, up to $5,000 annually, paid on professional medical education loans of a physician, registered nurse, nurse practitioner, or physician's assistant will be allowed as an itemized deduction if the individual agrees to practice in a rural, frontier or urban Health Professional Shortage Area (HPSA).

E. Long Term Care Tax Provisions

1. Expenditures for qualified long-term care services are deductible as medical expenses (i.e. subject to the 7.5% floor). Such services include diagnostic, preventive, therapeutic, rehabilitative, maintenance and personal care. Provision of such services must be contingent upon certification of impairment in three or more activities of daily living by a licensed health care practitioner;

2. Employer provided qualified long-term care coverage which meets certain consumer protection standards promulgated by the National Association of Insurance Commissioners, is excluded from an employee's taxable income. Premiums paid by an individual for qualified long-term care coverage are deductible as a medical expense (i.e. subject to the 7.5% floor);

3. NAIC is directed to promulgate standards for the use of uniform language and definitions in qualified long-term care coverage insurance policies, with permissible variations to take into account differences in state licensing requirements for long-term care providers.

F. Accelerated Death Benefits

Clarifies the income tax treatment of accelerated death benefits paid to terminally ill persons. Payments made under a qualified terminal illness rider can be received tax-free as if they were paid after the insured's death.

G. Tobacco Tax

The proposal increases the tax on tobacco by approximately $16.67 per pound of tobacco products, and would extend the tax to tobacco to be used in "roll-your-own" cigarettes. The new tax rates would be:

1. Cigarettes:

small cigarettes	$62 per thousand (i.e., $1.24 per pack of 20 cigarettes)
large cigarettes	$130.20 per thousand

2. Cigars:

small cigars	$5.82 per thousand
large cigars	65.875 percent of manufacturers price (not more than $155 per thousand)

3. Cigarette papers and tubes:

cigarette papers	3.88 cents per 50 papers
cigarette tubes	7.75 cents per 50 tubes

4. Snuff, chewing tobacco, pipe tobacco, "roll-your-own" tobacco:

snuff	$1.86 per pound
chewing tobacco	62 cents per pound
pipe tobacco	$3.49 per pound
"roll-your-own" tobacco	$3.49 per pound

5. The proposal would repeal the present-law exemptions for tobacco products provided to employees of the manufacturer and for use by the United States.

6. The proposal also includes several administrative and compliance provisions designed to improve the collection of the excise tax.

XIV. National Health Commission

An independent National Health Commission is established to oversee the health market much like the Securities and Exchange Commission oversees the financial markets.

A. Operation

1. The Commission shall be composed of 7 members appointed by the President with the advice and consent of the Senate. The Commission members will serve 6 year overlapping terms. No more than four members of the Commission may be from the

same political party. The members shall be compensated at level IV of the Executive Schedule. One member of the Commission shall be designated as the Chairman by the President.

2. The Commission members will have gained national recognition for their expertise in health markets.

3. The Commission shall appoint an Executive Director and such additional officers and employees it deems necessary to carry out its responsibilities under this act.

4. The Commission will be advised by expert private sector boards which focus on health benefits and health plan standards.

B. Responsibilities

1. Clarify the standard and basic benefits packages.

2. Develop and clarify the quality standards set in this act for Qualified Health Plans and provide for this information to be distributed to consumers in a standardized format. This information will include reporting prices, evaluating health outcomes and measuring consumer satisfaction.

3. Report to Congress on a biannual basis (described in Section I.,A.).

d. Develop risk adjustment factors for Accountable Health Plans.

e. Monitor the Fail-Safe Mechanism to prevent deficit spending (described in Section XI.,B,4.).

f. Recommend methods to achieve universal coverage if trigger mechanism is engaged in the year 2002 (described in Section I.,B.).

THE WHITE HOUSE

WASHINGTON

July 8, 1994

MEMORANDUM FOR LEON PANETTA

FROM: Patrick Griffin
Chris Jennings
Jack Lew
Steve Ricchetti

SUBJECT: Health Care Legislative/Strategic Options

Following up on yesterday's discussion about legislative strategy options for health care, this memo outlines the pros and the cons related to each of the options which we have been considering.

Option One: Senate moves up to universal coverage bill with a hard trigger mandate.

Arguments in Favor of Option One

(1) Clear definition allows for a relaunch and campaign.

(2) Protects the House and allows the House to move to the strongest possible bill.

(3) Assures that end product will include a mandate that will produce universal coverage.

Arguments against Option One

(1) Extremely unlikely to sustain a majority in the Senate.

(2) Starting too high may lead to a free fall to an unacceptable package in the Senate because rejection seriously undermines Mitchell and his proposal's credibility.

(3) This approach would likely ensure that conservative Democrats and Republicans would develop a "mainstream coalition" alternative package that we would find objectionable.

(4) Free fall in Senate would undermine the ability of the House to reach even a minimally acceptable universal coverage/mandate bill.

Option Two: Senate finds own level at which a majority can be sustained and that moves at a timetable parallel (or close to parallel) to the House.

Arguments in favor of Option Two

(1) Optimistic path -- a base closure approach to triggers (with a statutory employer/employee fallback) -- would produce a strong enough Senate bill for the House to proceed with its own bill.

(2) If the House is not willing to be at all out of step with the Senate on mandates, the optimistic path may also lead naturally to a "deal" with the House and the White House towards the end of floor consideration.

(3) Although there is a risk of the Senate lowering the bar below universal coverage, this approach has the chance of producing their own universal coverage package.

(4) Keeps options open so that the House/White House can choose to fight, make a deal or switch to a House first strategy as the Senate plays out.

(5) It smokes out Senate's true position and stretches out Senate consideration, allowing time for the House to move on a more concurrent schedule -- hopefully with a stronger position.

(6) Although it may be more difficult, this option still permits a credible relaunch and public strategy.

Arguments against Option Two

(1) Pessimistic scenario risks losing the mandate and universal coverage, which may well result in a loss of control. This could easily undermine subsequent efforts to reach a deal at the end.

(2) Pessimistic path also leaves House defending a mandate when the Senate is not, which may be untenable.

(3) Lowers the Senate mark right from the start.

(4) Delay in reaching a consensus on a single approach to universal coverage makes the relaunch around two different bills more difficult.

Option Three: **Try to make a deal between the House, Senate and White House as a starting point for both House and Senate floor action.**

Arguments for Option Three

(1) If the President and the leadership engage now they may be able to agree on a base closing or other approach that can be defended as universal coverage, avoiding the risk of the Senate collapsing and taking the House with it.

Arguments against Option Three

(1) Does not leave room for improvement in conference.

(2) Selling a bill which the left perceives as a weaker compromise,without a fight, will require an effort to hold on to both the right and the left, particularly in the House.

(3) It is difficult to see a front end compromise between the two Houses being acceptable as a starting point either in the House or the White House.

Option Four: Reverse Order and let the House go first.

Arguments for Option Four

(1) If the House is able to move ahead of the Senate, which is not at all certain, a higher mark can be set. At a minimum this preserves a stronger option in conference and may pressure the Senate to reach higher.

Arguments Against Option Four

(1) House is likely to oppose any effort which raises Member fears of being "BTUed"

(2) Any procedural shortcuts are likely to make an already difficult vote on the Rule even more difficult, particularly for members who are marginal to begin with.

(3) As a practical matter, House Rules action and Senate floor action commencing at the same time will result in House completing action prior to the Senate anyway.

ALTERNATIVE COMPROMISE PROPOSAL

This proposal builds on the Mitchell/Breaux/Boren-type model, with the following changes:

- It allows for a voluntary insurance market to achieve universal coverage.

- Employers and families who choose to purchase coverage receive subsidies to make coverage affordable (as in the Mitchell/Breaux/Boren-type model).

- For the working population, coverage objectives are established by size of employer, and are evaluated over a five year period.

  - **For firms with 100 or more employees:** After three years, unless 85% of the currently uninsured families with employees working for these firms are covered by their employers, a mandate goes into effect for these firms.

  - **For firms with 25 to 99 employees:** After four years, unless 80% of the currently uninsured families with employees working for these firms are covered by their firms, a mandate goes into effect for firms with 25 or more employees.

  - **For firms with fewer than 25 employees:** After five years, unless 75% of the currently uninsured families with employees working for these firms are covered by their firms, a mandate goes into effect for all firms.

- After five years, to ensure universal coverage, any family not covered through their employer must purchase coverage.

- Insurance market reforms apply upon enactment (e.g., guaranteed issue of coverage and community rating), but special provisions are made so long as the purchase of insurance is voluntary.

  - Insurers are permitted to apply a waiting period for pre-existing conditions when previously uninsured people purchase coverage.

  - Insurers are permitted to adjust community rates by age, but not by health status or other factors.

- To enhance competition and ensure fair application of fall-back premium caps, uncompensated care pools are formed so that the financial burden of serving the remaining uninsured is spread fairly across all health care providers.

This approach achieves universal coverage while providing a similar amount of deficit reduction as the Mitchell/Breaux/Boren-type model. However, without premium caps, the deficit would be substantially increased, and employers and families would pay much more.

PARTICULAR COMPLEXITIES ASSOCIATED WITH A TRIGGER WITHOUT UNIVERSAL COVERAGE AT THE START

Some proposals for triggered mandates require universal coverage from the start (e.g. an employer requirement above a certain size, with an individual requirement below that size), where the trigger applies only to whether certain employers are required to contribute for employees and their families.

Universal coverage makes it easier to establish a competitive and fair insurance market, because uncompensated care is eliminated and risk selection can be more easily controlled.

A trigger without universal coverage from the start (i.e. with no individual mandate to begin with) makes implementation more complicated in a number of ways, including:

- **UNCOMPENSATED CARE.** Without universal coverage, uncompensated care will continue to distort competition among providers and health plans. Uncompensated are pools are needed to spread the financial burden of serving the remaining uninsured fairly across all health care providers. Accurately measuring uncompensated care can be difficult, and uncompensated care pools require a new (and temporary) administrative structure.

- **PRE-EXISTING CONDITION EXCLUSIONS.** To guard against people delaying the purchase of insurance until they need health services, pre-existing condition exclusions for the previously uninsured are necessary.

- **AGE RATING.** Similarly, until universal coverage is achieved, age adjustments to premiums are necessary to prevent younger/healthier individuals from dropping existing coverage. Age rating is unfair, increases subsidy costs, and is more complicated for employers and families.

- **MEASUREMENT.** Evaluating whether coverage objectives have been met (particularly if the objectives vary by employer size) is more difficult and costly without universal coverage because there would not likely be an enrollment system that includes information about all families.