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TO: RECIPIENT: Chris Jennings

ORGANIZATION:

FAX NUMBER: 456-7431

FROM: PERSON SENDING: Bob Rozen

ORGANIZATION:

NUMBER OF PAGES: 2
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COMMENTS: Chris
FYI
this is ~~something~~
the thing we were
looking at

Congresswoman Marcy Kaptur
Ohio - Ninth District
June 1994 Working Draft

1A

AMERICAN HEALTH PLAN

Essential Features: A Medical Insurance Home for All

I. Health Insurance Coverage for each Citizen through Participation in any one of a broad range of Affinity Health Groups (AHG's) characterized by a common bond, chartered at the state level, but operating locally, with a federal tax number

* Federal definition of a Basic Benefit Plan for All Insureds in all Affinity Groups

* Shared Responsibility of Employer, Employee along with each citizen

* Simplification of Paperwork

* Portability

II. Market Standardization of Private and Public Insurance Marketplaces to include nine supplemental plan options beyond the Basic Plan

III. Quality Assurance

IV. Anti-Trust, Medical Malpractice and Tort Reform

V. Medical Education

AMERICAN HEALTH PLAN

SUMMARY

Assuring Health Coverage For All

I. PURPOSE AND BASIC ADMINISTRATIVE STRUCTURE
--A Medical Insurance Home For All

Every American should be covered by affordable, high quality private health insurance. Publicly assisted insurance should be provided only as a last resort. In achieving this goal, reformers must focus on covering people, not medical incidences and building on the employer-based system already developed in our nation. In Ohio's Ninth District, most people are very satisfied with the quality of care received, and a majority are satisfied with the type of coverage they have. The main concerns of persons in our region are: 1) insuring against catastrophic costs of long-term custodial care; 2) covering pre-existing conditions; 3) choosing the doctor a person desires; 4) keeping costs affordable; 5) streamlining the paperwork involved in medical insurance; 6) addressing the costs of long term care; and 7) covering the unemployed, part-time workers, small business employees and the self-employed. By building on the system now in place and remedying the shortcomings, those who are satisfied will remain satisfied and those who are left out will be included.

The economic impact of the lack of insurance for over 37 million Americans at any given point in time, with 8 to 10 million

people chronically uninsured, cannot be ignored. In our area, a few hospitals absorb more than 40% of the care provided as uncompensated. Thus costs are shifted to privately insured individuals, with insurance companies passing those costs onto subscribers. Reform of the system will eliminate hospitals' uneven absorption of uncompensated care and will not allow cost shifting.

Both employers and employees will be expected to make contributions to pay for coverage. The system must be structured in a way that allows individuals to control their plan as part of a group, with employers and employees sharing costs (or the government where subsidy is necessary).

-- Affinity Groups

The formation of carefully administered "affinity groups" of insureds at the local level--as defined by the states--including incentives to allow those on Medicare, Medicaid, and other government subsidized plans to join such groups--will provide a "medical insurance" home for each person. Each person must be enrolled in such a group. These groups will assure careful management and greater accountability of both the insurer and insured, will engender personal and more holistic care for each patient, will curb cost-shifting, and will allow for greater cost-consciousness through careful attention to each individual in every affinity group. There will be no set number of such affinity groups at the local level, but some floor will have to be set by each state on the minimum enrollment level (probably 1000 persons). This

requirement will guard against insolvency of smaller plans. Each citizen's enrollment, along with other minimal quality assurance information from each affinity group, will be reported to a National Health Board through the federal income tax system, with each affinity group being assigned a tax identification number. Through affinity groups, every citizen will be covered and assured continuity of care. Each person will be insured for all medically necessary conditions. Their insurance will be portable, continuous, and will provide coverage throughout the beneficiary's lifetime. Essential to high patient satisfaction is broad physician choice, to be negotiated through each affinity group.

Most affinity groups will be formed through employer health plans, but other alternative structures can be created locally through state law to achieve universal coverage. States and localities will have some discretion in defining the affinity group structure. Those citizens who fall into no other group will be able to obtain health benefits through the Federal Employee Health Benefit structure organized at the local level as an affinity group. Further, states will be given latitude to create other affinity groups to assure coverage of self employed persons, farmers, unemployed persons, veterans' health clinic users, public health or WIC site users, community health clinic users, Chamber of Commerce small business consortia, senior citizens center users, and hospital-based affinity groups serving low and moderate income insureds. Medicaid insureds and persons with no coverage will thus have several choices locally to assure competition between groups.

Medicaid as it currently exists will disappear.

Federal incentives also will allow, but not require, Medicare-eligible people to obtain supplemental insurance from an affinity group including through their former employer. If a Medicare eligible person joins such an affinity group, the National Health Board/HCFA will pay the group 95% of the cost of covering a retiree, while former employers will pay 5% of the normal Medicare cost. Former retirees will then have access to the common bond, benefits and freedom from paperwork which will be handled by the administrative services of that employer's affinity group. Further, the employer will retain insurance responsibility for their retirees. It is anticipated the typical affinity group will be able to deliver the Medicare portion for 90 cents on the Medicare dollar.

Insureds will use their AHG as their entryway into the health care delivery system. Through the locally organized AHG's, people will have a choice of primary care health care providers and physicians, and will be guided through the health care delivery system by that provider. The AHG will monitor each insured's medical history and continuum of care to guarantee a strong link between the individual and the health care delivery system. Careful management of each person in the AHG will ensure consistent, quality care in the most efficient manner. Keeping the AHG's at the local level maintains a sense of community and belonging which should encourage the members of the AHG to continue as healthy a lifestyle as possible.

Federal override of state requirements in specified areas,

including licensing for nurses, advanced practice nurses, physicians, and physicians assistants will be allowed.

Existing employer-based plans will be encouraged to emulate "affinity groups," that is, groups of individuals with some common bond, or "medical insurance home," that resemble self-administered, self-insured plans where insureds are all covered, pre-existing conditions accepted, costs monitored, and attention to the insureds' welfare is the hallmark.

-- Controlling Rising Costs and Promoting Responsibility

Through careful administration of the plan by persons hired through the plan and the inclusion of some consumers from each AHG on the governing board, each AHG will promote localized responsibility to strengthen plan management, quality, and cost consciousness. Over a five year period, consumer representation will be graduated to a maximum representation by consumers of up to one-third of the AHG's boards, as provided by state and federal law.

Careful administration by affinity groups is essential to curbing private and public costs. There are several indicators that the current system has flaws that the affinity group structure can address. First, it is assumed in this legislation that it not cost caps but rather careful administration by affinity groups that know their insureds' medical histories, with proper confidentiality maintained, and encourage their proper use of benefits that are the essential elements in curbing costs.

The current system must also be reformed to encourage more

responsible personal behavior that contributes to healthy lifestyles. States will encourage affinity group insurance rates to credit responsible behavior, and discourage unhealthy behavior. Similarly, good usage of the system and attention to one's own health needs and those of the family are not generally rewarded. The current publicly subsidized insurance demonstrates that people left to fend for themselves in accessing the system do not always use it properly. For example, people using Medicaid may not correlate inappropriate usage of emergency rooms with higher costs. Similarly, those who must find their own private health insurance may not be able to obtain the plan best suited to their needs because of the complexity of the existing insurance market. It is not surprising that many individuals carry unnecessary, duplicative private health insurance coverage for services that drive up costs overall. Individuals need help in using this complicated system. States will be directed to community rate AHG's.

Second, affinity groups can help individuals more effectively access and assess the broad range of health care delivery options on a more regular basis. Many current health plans really do not know their individual insureds, that is, there is little or no case management. For example, Medicare and Medicaid provide an accepted insurance payment stream that treats medical incidences. This system, however, does not provide a "medical insurance home" for insureds. These systems do not help individuals negotiate the current system at the local level even in such simple matters as paying premiums and bills, or in coordinating prescription drug

purchases. They do not encourage a patient to use his/her plan wisely or to access preventive measures. They do not encourage "the system" to know the insureds personally. The practice of medicine is sometimes lost in the bureaucracy of reimbursement systems. Too often, the current system places medical decisions in the hands of billing clerks, resulting in medical care being directed by financial intermediaries rather than persons closest to the patient.

-- Ending Job Lock and Uncompensated Care

Finally, able-bodied persons who are not working but receiving the entirety of their health insurance through government subsidy will be encouraged to pay back a portion of their benefits through voluntary service in a local Community Services Corps working in public health, long term care facilities, and community outreach programs such as shelters, school kitchens, and school aftercare or day care centers. This concept also can be more fully developed in the upcoming "Welfare Reform" legislation or the expansion of the National Community Service program.

II. MARKET STANDARDIZATION OF PLANS AND STREAMLINING ADMINISTRATIVE COMPLEXITY

-- Simplify the Market

The federal government will establish standards for a Basic Benefit Plan for all insureds in affinity groups. The federal government, through a National Health Board, will require the public and private insurance market to jointly standardize nine

supplemental plans beyond the basic plan. Through these elective insurance options, for instance including vision, dental, interstate and foreign travel, long term care, and abortion as an exceptional reproductive option in publicly subsidized plans, health services beyond the basic plan will be available to all citizens. This approach also will help streamline current administrative insurance complexity to reduce administrative overhead leading to higher costs. In addition, the basic and supplemental plans will balance services among prevention, acute care, rehabilitation, and chronic disease management. At least two of the health insurance supplemental plans must begin to phase in an insurance system to manage long term care. Although skilled nursing long term care is covered as a basic benefit along Medicare guidelines, insurance to protect against the catastrophic costs of long term custodial care must be developed. Some of the plans will guarantee that the "Family and Medical Leave" health benefits are available as an option, thus replacing the current system wherein coverage is uneven and excludes most families.

The utilization of one standard claim form for all provider admissions which the provider submits to the insurer will be required. Further, all providers will be required to submit claims initially to the affinity group rather than the patient to reduce paperwork error as well as patient anxiety, and then to each patient for verification and final processing for sign-off.

QUALITY ASSURANCE

Quality assurance can be strengthened by requiring consumer information for each affinity group's performance. The federal government through the National Health Board will direct the states to issue this report which will include all providers, physicians, and insurers rated on performance record and rate disclosures, as well as comparisons of benefits and costs for all insurance plans on an annual basis on a standard form.

ANTI-TRUST, MEDICAL MALPRACTICE AND TORT REFORM

Anti-trust, medical malpractice and tort reform provisions will be incorporated in any federal legislation. Alternative Dispute Resolution (ADR) will be mandatory before a malpractice claim can be tried. If the case goes to trial, the results of the ADR must be used as evidence. Compensation will be allowed for actual economic damages, and a cap will be placed on pain and suffering awards. Punitive damages will go into a state health insurance fund to support the state's health insurance subsidy payments. Attorneys who accept frivolous lawsuits will be financially sanctioned, with the money going into this state health insurance fund. Anti-trust regulations will be relaxed to allow a broad range of providers to negotiate with affinity group plans.

MEDICAL EDUCATION

In order to maintain enough committed physicians and other

health care professionals, and to build on the number of family practice and primary care physicians, the medical education system must ease the financial burden on its students. Federal policy will be implemented to reduce interest rates on student loans to a lower percentage than the current rates. A percentage of a new physicians' patients will be referred through the local affinity groups each year, thereby allowing the physician to gradually reduce accumulated debt financed through government assistance.

COMPLETE TEXT

SECTION ONE

ADMINISTRATIVE STRUCTURE

The heart of the system will be "Affinity Health Groups" set up at the local and regional levels, as defined by each state, with some federal guidance in order to maintain uniformity. (Refer below to federal government's role.) In order to capitalize on marketplace innovation, flexibility will be accorded the Affinity Health Groups in terms of how they organize and choose and pay participating providers. Functions of the Affinity Health Groups (AHG) will be as follows:

Marketing: Plans will have distribution systems (direct sales or agents/brokers) to sell products to employers, labor organizations, and other affinity groups.

Risk Assumption: The AHG's will accept full financial risk for the premium payments received. The AHG's, in turn, will share that risk through their relationships with providers. Premiums will be community rated with some effort within each group dedicated to credit healthy lifestyles, in order to ensure an equitable distribution of resources. Contracts will prohibit balanced billing.

Health Care Delivery System: The AHG will be responsible for organizing a full range of provider services for members. An

individual's primary physician will be responsible for coordinating health services needed by the individual. A primary physician is defined as the first health care provider of choice an insured sees for care of any medical conditions. The health care provider is appropriately licensed and includes internists, general and family practitioners, pediatricians, geriatricians, psychiatrists, clinical psychologists, and advanced practice nurses.

Payment By Plan To Providers: The AHG's will have available the full range of methodologies to pay providers, from full capitation to fee for service, to be determined by the AHG. AHG's would thus compete on the basis of price, service, and provider panels. The competition of the marketplace will contribute toward cost containment.

AHG's may be organized as for profit or not for profit. Employers may form their own AHG's to self-insure, and will retain ERISA preemption for five years, that is, exemption from state regulations. The National Health Board, in conjunction with the States, will have authority to decide whether AHG's will continue to retain ERISA preemption thereafter. Each AHG shall have a governing board to be prescribed by the states. The states will encourage over five years the inclusion of up to one-third of the members of the AHG's governance bodies be elected by its subscribers.

Consumers can select annually from among AHG's. In order to ensure every individual or family is insured through an affinity group, all AHG's will be assigned a number for income tax purposes (like school districts are now). Every individual--regardless of

income--will be required to file an income tax return, and must indicate the AHG in which they are enrolled on the tax form. Individuals and families whose religious or personal views dictate minimal or no health intervention may exempt themselves from the system, but in the event health care bills are incurred, must pay the expense out of pocket or work to reduce the debt through community service.

People who maybe locked into a job because they will otherwise lose their insurance will now be able to seek alternative employment and receive coverage, regardless of pre-existing condition from the first day of employment with the new employer. However, the employer through the AHG and as regulated by the states, may phase in depth of coverage of the Basic Plan and percent of contribution over a period of time. This bill defines 90 days as the target date for full coverage under the Basic Plan of that new employee.

Payment for Insureds Needing Subsidy.

Payment for insureds who require federal assistance will be on a sliding scale fee up to 250% of the poverty level, with the federal government paying the difference. The budgets of current federal health insurance programs, such as Medicaid, would be consolidated and used as the basis for these subsidies. State governments would contribute their current Medicaid match into the federal pool. If inequity exists between states on the current state reimbursement formula, the National Health Board will recommend changes to restore equity to state contributions within five years. If additional funds are needed to subsidize necessary

insureds, each affinity group could be taxed up to a level proposed by the National Health Board, in order to attain necessary subsidy dollars. In addition, employer contributions of greater than 80% will be considered an available source of revenue for subsidy purposes. Those insureds who are able-bodied and subsidized but not working will be required to contribute community service in partial payment for the services rendered. The framework of this community service network will be defined by the state, but could function as an adjunct to the public health system, the National Community Service structure, or be organized in conjunction with welfare reform. Because every insured will be required to file an income tax return, the IRS will verify income for insureds on behalf of the states.

It is the intention of this proposal that health care will be separated from welfare. Health insurance payments to subsidized individuals will take the form of Earned Income Health Tax Credits refunded on an annual basis. The section of the 1986 income tax revisions which removed millions of low income individuals and senior citizens from the federal income tax rolls will be revoked. Thus, every individual/family will be required to complete an income tax statement which lists the AHG to which the individual belongs. A minimum 50% contribution toward health insurance premiums of all full time employees (defined as 1500 hours per year) will be required from all employers, with the federal government subsidizing on a graduated basis those employers with less than 25 employees who both meet the criteria for a federal small business loan and pass

the discrimination test for 401(k) plan contributions. Subchapter S corporations will be exempt from subsidy. Again, employer contributions of greater than 80% will be considered taxable income and the revenues derived from this source will be directed toward paying the insurance costs of low income or other uninsured citizens.

Federal Government's Role:

* create a National Health Board for federal oversight, financial involvement, and reporting purposes
* set a minimum benefit package and require market standardization of supplemental plans
* set a minimum contribution for subscribers and employers
* set the sliding scale fee for subsidized subscribers and fund the subsidies
* require community rating by standard metropolitan statistical areas

State's Role:

* All AHG's will be regulated by the State Department of Insurance regarding financial solvency. All AHG's will be required to report to the State Department of Insurance a federally standardized "report card" showing quality, utilization, outcomes, salaries of office-holders, and profit margins. The State Department of Insurance will ensure that all AHG's follow community rating, guarantee renewals, and cover all pre-existing conditions of each insured.
* The State Health Department will be responsible for oversight of

medical quality assurance, utilization, and outcomes. The federal government will assemble this information from all states under a standard format to be developed by the National Health Board through HCFA.

Underpinning the system of health care is a strengthened role for public health. The primary focus on public health will be through its infrastructure of public health nurses, sanitarians, health educators, and special focus programs as a method of finding people who fall through the cracks and enroll them in affinity groups. AHG's will be authorized to contract with the public health system and other public health providers such as the Visiting Nurse Service to provide these services to its members. The public health system holds enormous unmet potential as a focal point for consumer education to promote prevention and healthy living. The federal government should strengthen the public health system, including some additional resources, to perform these functions.

SECTION TWO

STANDARDIZATION OF PLANS AND STREAMLINING OF ADMINISTRATIVE COMPLEXITY

-- Claim Forms

A standard claim form, based on the White House's Medical Claim Form Prototype, will be developed by the National Health Board in conjunction with HCFA. This form will be used for all medical intervention. With regard to durable medical equipment (DME), a three-part prescription pad will be developed which will allow the physician to use the same form for submission of DME prescriptions to all insurance carriers. One copy of the prescription remains in the patient's chart, and two copies go to the provider of the DME. One copy is subsequently forwarded to the payor.

-- Credentialing

Regional credentialing offices--with federal oversight through the National Health Board/HCFA--will be set up to provide uniformity of the physician credentialing process. All health care entities will pay a fee to the regional credentialing office to obtain all necessary information on a physician. This eliminates the tremendous duplication of effort by hospitals, insurance companies, HMO's, and all other health care facilities which must credential their physicians.

-- Other Federal Health Programs

The VA system, CHAMPUS/CHAMPVA, and Medicare will remain, with individuals utilizing those systems being afforded the opportunity to join affinity groups or organize into affinity groups. Individuals always will retain the option of selecting from a number of affinity groups, but will only be able to be enrolled in one at a time.

-- Basic and Supplemental Plans

The federal government will establish standards for a Basic Benefit Plan for all insureds in affinity groups. The federal government, through a National Health Board, will require the public and private insurance market to jointly standardize nine supplemental plans beyond the Basic Plan.

BASIC BENEFIT PACKAGE

With an annual individual/family deductible of $200/$400 and an annual individual/family maximum out-of-pocket expense of $1000/$2000, the following services will be covered in a Tier 1 Basic Benefit Plan:

<u>BASIC BENEFIT PLAN - Tier I</u>

* prenatal, neonatal, and well baby care covered at 100%
* preventive care, including injections/immunizations, office visits, and annual physicals, covered at 100%
* prescription drugs and biologicals
* outpatient diagnostic, laboratory and x-ray services, with pre-certification for high cost tests
* mental health coverage would not be based on a diagnostic code,

but rather 100% coverage to include 45 days inpatient; thirty sessions per year of individual and group therapy will be covered, with a $20.00 copay per session.

* long-term case management for severe mental illness

* inpatient care including semi-private room & board, ICU & CCU, preadmission testing, physician visits, surgeon and technical surgical assistants, anesthesia, nursing, ancillary services, and maternity

* inpatient and outpatient surgical benefits

* emergency services defined as life threatening

* Hemodialysis

* chemotherapy and radiation

* skilled nursing and home care based on Medicare guidelines;

* durable medical equipment and prosthetics;

* hospice coverage following Medicare established guidelines;

ENHANCED BASIC BENEFIT - Tier 2

The National Health Board will evaluate the feasibility of phasing in the following benefits to the Basic Benefit Plan within 3 years after the adoption of this legislation. Means testing will be required to ascertain which insureds require government subsidy to meet the costs of their insurance premium:

* specialty care (physical/occupational/speech therapy, podiatry, etc) covered only when services can reasonably be expected to restore significant improvement or prevent significant deterioration;

* reproductive services covered at 80% (in publicly assisted benefits abortion would not be covered in the basic plan but would

be available as an elective option);

* behavioral management techniques;

* two admissions per two years for substance abuse treatment;

* medically necessary plastic and reconstructive surgery.

For both Tier 1 and Tier 2 benefits, except where specified with different payments, coverage will be at 80% up to the maximum out-of-pocket. After the maximum has been met, coverage will be at 100%. Maximum lifetime limits imposed by insurance companies will not be allowed, thus eliminating financial devastation because of a catastrophic illness.

Consumers can purchase supplemental plans which provide coverage in addition to the Basic Plan and the Enhanced Basic Plan. The supplemental plans will be limited to nine, as described below (see attached) with graduated premiums.

STANDARD PLAN OPTIONS

A	B	C	D	E	F	G	H	I	J
BASIC BENEFITS TIER I	BASIC BENEFITS	BASIC BENEFITS	BASIC BENEFITS	BASIC BENEFITS	BASIC BENEFITS	BASIC BENEFITS	BASIC BENEFITS	BASIC BENEFITS	BASIC BENEFITS
BASIC BENEFITS TIER II	DENTAL (ORTHODONTIA)			DENTAL (ORTHODONTIA)	DENTAL (ORTHODONTIA)	DENTAL (ORTHODONTA)	DENTAL (ORTHODONTIA)	DENTAL (ORTHODONTIA)	DENTAL (ORTHODONTA)
		VISION		VISION	VISION	VISION	VISION	VISION	VISION
			ABORTION SERVICES		ABORTION SERVICES	ABORTION SERVICES			ABORTION SERVICES
				HEARING	HEARING	HEARING	HEARING	HEARING	HEARING
						FAMILY + MEDICAL LEAVE	FAMILY + MEDICAL LEAVE	FAMILY + MEDICAL LEAVE	FAMILY + MEDICAL LEAVE
							FOREIGN + INTERSTATE TRAVEL	FOREIGN + INTERSTATE TRAVEL	FOREIGN + INTERSTATE TRAVEL
								CHIROPRACTIC	CHIROPRACTIC
				LONG TERM CARE				LONG TERM CARE	LONG TERM CARE

SECTION THREE

QUALITY ASSURANCE

The primary objective of quality assurance is to provide consumers with information--in understandable language (use Flesch Test)--in order that they may make quality health care decisions which are cost effective and accountable. This objective will be achieved by requiring the following:

Credentialing:

Develop a provider "report card" which includes:

* outcome-based indicators which include mortality statistics, infection rate, readmission rate, and complications;
* satisfaction indicators which include waiting time standards, length of time for appointments, time spent with patient, communication skills, satisfaction with service and treatment, office location, office policies, and office staff;
* financial indicators which include costs for office visits, treatment, missed appointments, and prescriptions.

Tracking will link medical appropriateness with financial appropriateness. Credentialing criteria will be based on the providers' national and regional recognized standards, delineating differences between populations and urban v. rural areas. Physicians will be measured by following clinical pathways of care, as defined by Milliman and Robertson Health Care Management Guidelines. Medical necessity guidelines will follow those established by the Value Health Sciences Medical Review System. The criteria will be developed into an overall quality index which will

be consistently measured. AHG's will provide all credentialing information to subscribers. Federal and State governments will also assemble this information and make available annually.

Preventive Health Services:

Preventive health services will be developed for all age groups following the recommendations of both the "Guide to Clinical Preventive Services: Report of the U.S. Preventive Services Task Force" and the various medical associations. Both make recommendations on preventive care based on age groups.

Patient Education:

Information on the following will be provided (in language such as the Flesch Test) through each AHG:

* preventive health care;
* specific diseases;
* medications;
* treatment;
* living wills, advanced directives, and Durable Powers of Attorney;
* health risks, patient responsibilities, and non-compliance linkage of financial costs to patients;
* monitoring of patient education and outcomes, following the goals of Healthy People 2000.

SECTION FOUR

ANTI-TRUST, MEDICAL MALPRACTICE AND TORT REFORM

States will be encouraged to adopt reform of medical malpractice laws and torts by linking federal health subsidies to compliance. Reform should achieve the following goals:

* the formation of Alternative Dispute Resolution councils before which the parties must appear before taking a case to trial;
* the prohibition of collection from more than one entity in a lawsuit (e.g. collecting from the hospital, all physicians, all nurses, and all staff);
* capitation of economic damages will be determined by the state;
* a cap on "pain and suffering" of $250,000.00;
* any punitive damages awarded will be directed to state health care budgets rather than the plaintiff;
* financial penalty--determined by the state and directed to state health care budgets--for attorneys who accept frivolous suits;
* fees awarded to attorneys will not exceed 20% of $1 million awards, 10% of $2 million awards, and 5% of awards of $3 million or more.

Anti-trust laws will be relaxed to allow physicians and other providers to consult with one another regarding fees for services. This will allow them to be competitive among AHG's.

SECTION FIVE

MEDICAL EDUCATION

In order to assist physicians, nurses, and allied health professionals in reducing the debt incurred as a part of their education, and to provide care in necessary and often underserved areas, the
following methods of debt reduction will be allowed:

* referrals to affinity groups to help offset the cost of federally subsidized patients;
* service in public health or community clinics, secondary or post secondary institutions' health clinics, Native American reservations, and migrant centers;
* practice through interdisciplinary health care teams involving a network of professionals;
* lower interest loans, with stronger enforcement for repayment;
* paying back a smaller rate at the beginning of one's practice;
* erasure of 25% of one's debt for those who enter into underfilled medical disciplines.

A lottery selection for specialty training programs will maintain equal opportunity for all applicants. Selection into advanced training will be based only on ability and merit.

All providers will be required to keep current with medical advances by completing Continued Medical Education (CME) credits--the amount of which will be determined by the states' boards--in order to maintain licensure. Although licensure will be maintained at the state level, the federal government would mandate quality of practice, to include a national network for removal of licensure.

The regulatory bodies overseeing licensure will be made up of an interdisciplinary team. Thus, no one health discipline has control.

ONE HUNDRED THIRD CONGRESS

G.V. (SONNY) MONTGOMERY
CHAIRMAN

U.S. House of Representatives

COMMITTEE ON VETERANS' AFFAIRS
335 CANNON HOUSE OFFICE BUILDING
Washington, DC 20515

May 26, 1994

Honorable Richard Gephardt
Office of the Majority Leader
U. S. House of Representatives
Washington, DC 20515

Dear Mr. Leader:

As you begin to formulate a strategy for House consideration of H.R. 3600, I want to follow up on our discussions about Committee's plans for our portion of the bill. As I indicated to you, our Subcommittee on Hospitals and Health Care ordered the bill reported to the full Committee with amendments on May 11, 1994. Although I am not certain what will happen to the abortion restrictions when the full Committee takes up the bill, the rest of the amendments recommended by the Subcommittee seem to be non-controversial and have been endorsed by all of the veterans organizations.

There are very important budget and financing issues raised by H.R. 3600 as introduced, and since some of them affect not only our Committee but the Armed Services Committee as well as other committees with jurisdiction over the Indian Health Service, I want to make sure you are apprised of them. In my view, a favorable resolution of these issues is fundamental to meeting a commitment which the First Lady made in meetings with representatives of the major veterans organizations. Mrs. Clinton specifically told these organizations at a meeting that Senator Rockefeller and I attended that "all veterans will have the security of knowing that they are guaranteed a comprehensive package of benefits and access to the highest quality care" and the Health Security Act makes that promise to <u>all</u> Americans.

Obviously, neither the Budget Act as it is written today nor previous legislative precedent anticipates the potential huge shifts in budgeting and accounting for health care spending in this country. As CBO noted in its "Analysis of the Administration's Health Proposal":

> *Two aspects of the Administration's health proposal have made its budgetary treatment particularly contentious. First, the proposal is innovative and complex, and existing budgetary*

concepts and precedents are less helpful than usual. Second, the proposal does not spell out the requirements for financial reporting by the Federal government or the fiscal rules controlling the system of regional and corporate health alliances.

While the budget issues presented by the entire bill are of far greater consequence than those presented by the portion of the bill dealing with veterans health care, it is not clear to me that Members will easily accept the changes necessitated by any universal health care legislation. I would like to propose three principles that would be helpful in assessing the changes in scorekeeping and accounting which adoption of legislation providing for universal health care coverage may require.

- The true effect on the deficit should be the focus of any budget analysis of health reform.

- Our assessment of health reform's effect on the deficit should focus on the long term impact (at least five years), not on the effect in any particular year.

- The distinction between mandatory and discretionary spending, and the consequences of those classifications, should not be a litmus test for health reform policy choices.

The proposed Health Security Act offers guaranteed health coverage to all Americans, including veterans and members of the armed forces and their families. Obviously, if funding support for health care for these Americans is subject to annual changes and curtailments (as it has been for veterans), there is no feasible way to insure that sufficient resources are available to provide the health care which persons who enroll with the VA are guaranteed. According to a preliminary assessment by the Congressional Budget Office, H.R. 3600 would have the effect of changing current spending for veterans' health care from discretionary to mandatory spending. CBO also expects that the resulting increase in direct spending would be completely offset by reduced discretionary spending. Overall, CBO concurs with the OMB estimate that the net effect of the veterans portion of H.R. 3600 would be billions of dollars in deficit reduction.

As I indicated in our discussions, the Subcommittee has reported amendments to H.R. 3600 which would establish a financing mechanism to assure funding for the care of service-connected and low-income veterans who choose VA as their health care provider. The Subcommittee also made other changes which reduce the savings from the level projected by CBO for the bill

as introduced. I believe these changes are sound, and the amended bill would still provide net savings of more than $3.3 billion over fiscal years 1995-1999. However, savings of this magnitude may be substantially reduced by modifications to the bill now being discussed by other committees with jurisdiction over the entire bill. While I cannot predict the final savings associated with the veterans provisions, I am committed to assuring that the veterans portion does not add to the deficit over the first five years.

Mr. Leader, there are complicated choices ahead for all members on this bill. But we need to settle at the outset the proposition that if veterans choose to enroll with a VA plan, funding for their health care is secure and guaranteed, as it is for all other Americans under H.R. 3600. Inevitably, this means we cannot look to discretionary appropriations to fund services guaranteed under health reform legislation if VA is to have a chance to survive. VA must undergo a fundamental transformation to operate successfully in the marketplace, and it will have to make changes based on a clear notion of what future revenue it might expect as a ~~competitive health care provider~~.

I believe the choices and accompanying Budget Act changes will be far less controversial if we can agree on the three principles I have outlined above. However, if the change in accounting for veterans health care proposed in H.R. 3600 cannot be accommodated, I think veterans' support for the Administration's proposal or any other health reform legislation will evaporate.

My staff has ~~kept the~~ staff of the Budget Committee fully apprised of what is taking place in our Committee, and I want to make certain you are aware of what our Committee is doing on subtitle B of Title VIII of the bill, the portion dealing with health care for our nation's veterans.

I will schedule a full committee markup when the three major committees have reported a bill.

Sincerely,

Sonny

G.V. (Sonny) Montgomery
Chairman

GVM/per

cc: Honorable Martin Sabo

THE LEWIN ANALYSIS OF COOPER/BREAUX

THE MIDDLE CLASS LOSES

MILLIONS OF PEOPLE

	NUMBER CURRENTLY UNINSURED	NUMBER WHO RECEIVE INSURANCE	NUMBER WHO REMAIN UNINSURED
PEOPLE BELOW POVERTY	9.3	7.9	1.4
100-150% OF POVERTY	6.0	3.7	2.3
ABOVE 150% OF POVERTY	21.9	3.2	18.7
TOTAL	37.2	14.8	22.4*

	NUMBER CURRENTLY UNINSURED	NUMBER WHO RECEIVE INSURANCE	NUMBER WHO REMAIN UNINSURED
UNDER AGE 18	9.7	4.3	5.4
18 - 34	14.4	4.9	9.5
OVER 34	13.1	5.6	7.5
TOTAL	37.2	14.8	22.4*

*CBO ESTIMATES 25 MILLION REMAIN UNINSURED

THE LEWIN ANALYSIS OF COOPER/BREAUX

FEDERAL SUBSIDIES INCREASE COVERAGE NOT THE MARKET

	NEWLY INSURED	
	NUMBER PEOPLE\MILLIONS	PERCENT
INSURANCE MARKET REFORMS	1.1	7
INCREASE TAX DEDUCTIBILITY	1.1	7
GOVERNMENT PAYS 100% OF THE PREMIUM	7.9	53
GOVERNMENT PAYS A SIGNIFICANT PORTION OF PREMIUM	4.7	33
TOTAL	14.8	100%

THE LEWIN ANALYSIS OF COOPER/BREAUX

PERCENT OF POPULATION REMAINING UNINSURED

	TODAY %	AFTER REFORM %
UNDER 18	13.9	7.7
18 - 24	29.4	20.2
25 - 34	19.5	12.5
34 - 65	13.0	7.7
TOTAL UNDER AGE 65	16.0	9.6

ADDITION TO DEFICIT UNDER COOPER/BREAUX

TO ACHIEVE 91% COVERAGE

BILLION $

	1996	1997	1998	1999	2000	2001	2002	2003	2004	TOTAL
WITH TAX CAP	35	46	42	36	30	32	31	27	22	301
WITH-OUT TAX CAP	41	61	58	53	48	52	54	51	47	465

SOURCE: CBO

	NEW GOVERNMENT COST 1998	NEWLY INSURED PEOPLE	FEDERAL COST PER PERSON
1998 FEDERAL COST FOR EACH NEWLY INSURED PERSON	$42 BILLION	14.8 MILLION	$2,838 PER PERSON

BREAUX-COOPER COST/TAX CAP TABLE

	Comprehensive Benefits	Basic Benefits
Program Cost Without Tax Cap	350	150
Tax Cap	-50	-150
Total	300	0