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202/225-0600

LEADER'S TASK FORCE ON HEALTH

U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, D.C. 20515

FOR IMMEDIATE RELEASE
15 SEPTEMBER 1993

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HOUSE REPUBLICANS INTRODUCE MAJOR HEALTH CARE PACKAGE
Michel, Gingrich Among 106 Co-Sponsors

House Republican leaders and members of the Leader's Health Care Task Force today introduced comprehensive health care reform legislation – the Affordable Health Care Now Act. With 106 co-sponsors, this is the most widely supported health care reform legislation in either body of Congress.

"Our bill represents a reasonable, common sense approach to health care reform," said Republican Leader Bob Michel. "It reflects our view that the health care concerns of the American people can be most effectively addressed through workable, serious reforms and not through the imposition of a risky, complex and untried scheme."

"This bill reflects a consensus of important reforms that address the great bulk of concerns of the American people," added Republican Whip Newt Gingrich. "These reforms will improve access to affordable health care and help contain the growth in costs while enhancing the quality of care. And this bill – because it is affordable to the American family and the economy – can be passed this year. In the next few weeks, we look forward to working with Democrats and hope to have their support on our effort."

The new legislation requires that employers must offer, though not necessarily pay for, insurance coverage for all their workers. Through imposition of small group market reforms, the bill will make it easier for small businesses to provide insurance to workers.

In order to control health care costs, the bill includes seminal reform of the U.S. malpractice system and would allow and encourage the creation of personal medical saving accounts. Administrative reforms and provisions that would punish perpetrators of fraud and abuse are also included in the legislation.

The bill would increase access to health care in underserved areas by expanding Community and Migrant Health Centers and other rural health care programs.

*** Attached are highlights of the bill, an outline of the bill's provisions, and a list of co-sponsors ***

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EXECUTIVE COMMITTEE ON
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SELECT COMMITTEE ON
HUNGER

Congress of the United States
House of Representatives
Washington, DC 20515-1314

FAX COVER SHEET

To: Chris Jennings

Office: _____

Fax #: _____

Comments: This is the final version ... a few changes from last night.

****

From: Tandi

Pages Including Cover Sheet: 17

Congressman J. Dennis Hastert
Fax: 202/225-0697
Tel: 202/225-2976

SUMMARY: THE AFFORDABLE HEALTH CARE NOW ACT OF 1993

TITLE I: IMPROVED ACCESS TO AFFORDABLE HEALTH CARE

SUBTITLE A: INCREASED AVAILABILITY AND CONTINUITY OF HEALTH COVERAGE FOR EMPLOYEES AND THEIR FAMILIES

PURPOSE: To expand access to affordable group health coverage for employers, employees and their families and to help eliminate job-lock and the exclusion of such individuals from coverage due to preexisting condition restrictions.

This section:

1. Requires employers without existing health benefit plans to offer to eligible employees at least one plan meeting an actuarially defined standard of coverage. The plan must cover essential and medically necessary medical, surgical, hospital, and preventive services. Employers are not required to make any premium payments for their employees.

2. Encourages employers to facilitate employee enrollment in health plans through multiple employer purchasing arrangements or state-sponsored accessible health benefit systems.

3. Limits preexisting condition restrictions under all employer health benefit plans, including self-funded plans. Eliminates pregnancy as a preexisting medical condition and provides coverage for newborns at birth.

4. Ends job-lock by assuring continuous availability of health coverage by prohibiting preexisting condition restrictions for those who are continuously covered.

5. Prohibits employer health plans from being canceled or denied renewability except for the following reasons: (a) nonpayment of premiums, (b) fraud or misrepresentation, and (c) noncompliance with plan provisions.

SUBTITLE B: REFORM OF THE HEALTH INSURANCE MARKETPLACE FOR SMALL BUSINESSES

PURPOSE: To expand access to health insurance by making private health insurance marketed to small employers more affordable and available regardless of an employee's health status and previous claims experience.

This section:

1. Requires insurers, who sell insurance in the small group market to offer health benefit plans to all companies who employ 2 to 50 employees. Insurers would be required to sell at least three plans to small employers: (a) a Standard Plan to be comparable in benefits to those plans currently available in the small group health insurance market; and (b) a Catastrophic Plan with higher cost-sharing provisions for health care services; and (c) a Medisave Plan that includes catastrophic coverage with an integrated family medical savings account.

   Insurers must accept every small employer and every eligible employee of a small employer who applies for coverage under a plan. Insurers may not place restrictions on the eligibility of an individual to enroll (e.g., no medical underwriting) as long as such an individual is a full-time employee. Uninsured employees would have a choice among the three plans.

2. Requires plans to cover essential and medically necessary medical, surgical, hospital, and preventive services. The National Association of Insurance Commissioners (NAIC) will determine target actuarial values for the Standard and Catastrophic Plans. Insurers would have the flexibility to develop the benefit provisions as long as they meet the target actuarial values established by the NAIC for each plan.

   The Medisave Plan must include catastrophic coverage plus an integrated medical saving account providing for the reimbursement of health care expenses including the deductible and/or coinsurance.

3. Places limits on premium rate variations charged to small businesses which would be based on underwriting factors other than geography, age, gender, and plan design.

4. Limits annual increases to the change in an insurer's new business rate plus 15 percentage points.

5. Encourages States to establish reinsurance pools.

SUBTITLE C: IMPROVED EMPLOYER PURCHASING POWER AND MORE AFFORDABLE HEALTH COVERAGE

PURPOSE: To improve access to health coverage and lower insurance costs for both small and larger employers by encouraging the establishment of multiple employer purchasing arrangements and by eliminating costly state regulations.

This section:

1. Facilitates the ability of employers to form groups for the purpose of purchasing health coverage. Reduces costly regulation, allows any group of employers to purchase insurance, and helps ensure the solvency of self-funded multiple employer health plans.

2. Helps lower costs, eliminates inter-state barriers, and provides a level playing field between insured and self-funded plans by eliminating burdensome and expensive state mandates.

3. Encourages the formation of multiple employer health plans by removing IRS regulatory barriers involving geographic limitations and business commonality tests which now prevent such groups from using tax-exempt 501(c)(9) trusts to lower costs.

4. Preempts state laws which restrict the development of cost effective managed care programs. The provision sunsets five years after enactment.

SUBTITLE D. HEALTH DEDUCTION FAIRNESS

PURPOSE: To provide the self-employed and uninsured individuals with tax treatment for the purchase of health insurance equal to that of other Americans who now receive a tax exclusion for employer-paid health benefits.

This section:

1. Gradually increases the current law tax deduction for the cost of health insurance premiums for the self-employed from 25 percent to 100 percent.

2. Gradually increases the tax deduction for the cost of health insurance premiums for those not receiving employer-provided health coverage to 100 percent.

SUBTITLE E: IMPROVED ACCESS TO COMMUNITY HEALTH SERVICES

Part 1. Increased Authorization for Community and Migrant Health Centers

PURPOSE: To expand capacity of communities to meet the health care needs of their citizens, especially lower income and uninsured individuals through expanding the number of community and migrant health care programs and the resources available to them.

1. Increases the current authorization for Community and Migrant Health Centers (C/MIICs) to expand access to primary care services. ($1.5 billion over 5 years)

PART 2. Community Coordination Demonstration Grants

PURPOSE: To facilitate community health services planning and improve delivery of health care services.

1. Authorizes demonstration grants for communities for improved delivery and coordination of health care services ($45 million over 5 years).

SUBTITLE F: IMPROVED ACCESS TO RURAL HEALTH SERVICES

PART 1: Rural Emergency Medical Services Amendments

PURPOSE: To improve emergency medical services operating in rural America.

This section: ($15 million)

1. Establishes an Office of Emergency Medical Services (EMS) to provide technical assistance to state EMS programs.

2. Provides incentives for improving state EMS programs through a matching grant program. These grants will encourage better training for health professionals and provide necessary technical assistance to public and private entities which render emergency services.

3. Provides federal grants to states for demonstrations of telecommunications links between rural and urban health care facilities.

PART 2: Air Transport of Rural Victims of Medical Emergencies

PURPOSE: To develop air transport systems which will enhance access to emergency health care services.

This section: ($15 million)

1. Provides federal grants to states for the development or improvement of rural air transport systems for medical emergencies.

PART 3: Extension of Special Treatment Rules For Medicare Dependent, Small Rural Hospitals

PURPOSE: To continue adjustments in payments for rural Medicare dependent hospitals in order to assure ready access to health care.

This section:

1. Extends adjustment included in the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) providing small rural Medicare dependent hospitals with an additional hospital payment to offset unique financial risk from treating a high percentage of Medicare patients under the prospective payment system. ($70 million for one-year extension)

PART 4: 24 Hour Emergency Care in Rural Areas

PURPOSE: To establish Rural Emergency Access Care Hospitals (REACHs) for the purpose of providing 24 hour emergency care in rural areas.

This section:

1. Permits existing rural community hospitals participating in the Medicare program, to maintain their Medicare status as a rural community hospital after meeting criteria of eligibility as a rural emergency access care hospital.

SUBTITLE G: STATE FLEXIBILITY IN THE MEDICAID PROGRAM: THE MEDICAL HEALTH ALLOWANCE PROGRAM

PURPOSE: To allow states to develop guaranteed access to health insurance for the entire state population. States will be provided more flexibility and allowed to extend Medicaid to cover more of the uninsured while working with the private sector to bridge the gap between Medicaid and employer-provided insurance.

This section:

1. Allows States to redirect Medicaid funds into Health Allowance Programs where eligible individuals will be able to enroll in private-market health plans.

2. Provides States with the option of increasing eligibility to the Health Allowance Program up to 100% of the Federal Poverty Level.

3. Provides States with the option of setting up a sliding scale subsidy whereby individuals up to 200% of the Federal Poverty Level could buy-in to the Health Allowance Program.

4. Allows States to develop pooling mechanisms so that all other families and individuals without insurance (part-time workers, early retirees, etc.) can join Accessible Health Benefit Systems for the purpose of buying health insurance.

SUBTITLE H: MEDICAID PROGRAM FLEXIBILITY

PURPOSE: To give states more flexibility to enroll Medicaid beneficiaries in HMOs and PPOs. Under current Federal law if a State wants to require Medicaid recipients to enroll in health maintenance organizations (HMOs), it must submit a waiver application to the Health Care Financing Organization (HCFA). These waiver applications are granted for only a limited period of time and cannot be renewed. These procedures have greatly limited the ability of States to enroll Medicaid beneficiaries on HMOs.

This provision:

1. Allows States to enroll Medicaid beneficiaries in HMOs and PPOs without having to submit cumbersome waiver applications. States would be given the option to mandatorily enroll Medicaid beneficiaries provided they meet Federal quality assurance standards.

TITLE II: HEALTH CARE COST CONTAINMENT AND QUALITY ENHANCEMENT

SUBTITLE A: MEDICAL MALPRACTICE LIABILITY REFORM

PART 1: Medical malpractice and product liability reform

PURPOSE: To improve access to fair compensation for those injured while receiving medical care and to increase the availability of health care services by reducing the costs of both medical malpractice liability premiums and defensive medicine.

This section:

1. Initiates Federal reform of medical malpractice liability actions by linking federal dollars to malpractice reform initiatives.

2. Requires that health care liability action include, in addition to health care providers and professionals, medical product producers. Medical products mean both drugs and devices as defined in the Federal Food, Drug, and Cosmetic Act by the Food and Drug Administration (FDA). That punitive damages relating to medical product liability not be awarded against a medical product producer if the drug or device was subject to approval by the FDA or generally recognized as safe and effective as established by the Federal Food, Drug, and Cosmetic Act, except in the case of withheld information, misrepresentation, or illegal payment.

3. Requires all medical liability disputes in a state to be initially resolved by a dispute resolution process prior to entering the court system as a condition of the receipt of federal funds under federal health related programs, including tax deductibility of health insurance expenses.

4. Places a $250,000 cap on non-economic damages. (Punitive damages are handled separately.)

5. Directs that punitive damages awarded by courts be paid to States to assist in funding their efforts to reduce medical malpractice. Includes a definition of punitive damages as compensation over and above the actual harm suffered, awarded for the purpose of punishing a person for conduct deemed to be malicious, wanton, willful, or excessively reckless.

6. Allows for structured periodic payment of compensatory awards.

7. Places limits on attorneys' contingency fees.

8. Limits the liability of the defendant to his/her proportion of negligence.

9. Sets a uniform statute of limitations for plaintiffs of all ages.

10. Clarifies a uniform standard for determining that a defendant has acted negligently.

11. Imposes a higher standard of proof for liability associated with certain obstetric services.

12. Discourages frivolous court actions by requiring the plaintiff to pay the defendant's legal fees, if the plaintiff loses.

13. Allows Federal and State courts to determine a fee bond amount based on a reasonable determination of anticipated court costs and includes the use of certain property in lieu of bond.

PART 2: Requirements For State Alternative Dispute Resolution Systems (ADR)

PURPOSE: To permit the Secretary of HHS (in consultation with the Attorney General) to be able to certify the States' alternative dispute resolution systems.

This section:

1. Establishes basic requirements for ADR. It requires the Secretary to report to Congress within 5 years about the effects of State ADR systems on cost, access, and quality of health care.

SUBTITLE B: ADMINISTRATIVE COST SAVINGS

PURPOSE: To reduce the administrative cost of our health care system by streamlining the insurance billing system and utilizing the latest technological innovations in information processing.

PART 1: Standardization of Claims Processing

PURPOSE: To simplify payment for medical services; eliminate unnecessary overhead and administrative cost; reduce billing fraud and abuse; improve the collection of clinical information for research; and improve health care quality.

This section:

1. Mandates the Secretary of Health and Human Services (HHS) to develop a standard claims form and data set for electronic transmission of health coverage information and billing data.

2. Requires the Secretary of HHS to set standards for the use of magnetized Medicare cards and issue them to beneficiaries.

3. Requires hospitals, physicians and carriers to conform to the uniform claims reporting standards.

4. Requires the Secretary of HHS to design a clearinghouse for primary and secondary payor information for the working aged and other Medicare beneficiaries who may have employer-provided coverage.

5. Requires use of the Social Security number as the identifier for all medical claims.

6. Provides protection for individual privacy regarding claims and medical records.

7. Overrides state laws which prevent the sole use of electronically transmitted claims and other medical records for payment purposes.

PART 2: Electronic Medical Data Standards

PURPOSE: To improve quality of patient care by assuring the development of more usable medical records.

This section:

1. Requires all hospitals to put in place an electronic patient care information system by January 1, 1996, which meets standards set by the Secretary.

PART 3: Development and Distribution of Comparative Value Information

PURPOSE: To provide consumers information necessary for cost and quality conscious purchasing of medical services.

This section:

1. Requires states to make available to consumers information on the comparative value of medical services.

SUBTITLE C: MEDICAL SAVINGS ACCOUNTS (MEDISAVE)

PURPOSE: To provide incentives for health care cost consciousness and allow any savings to accrue to the individual and family through the use of Medical Savings Accounts.

This section:

1. Allows tax-free deposits to Medisave Accounts to reimburse medical expenses and pay for long-term care, catastrophic, Medigap, and Medicare premiums.

2. Requires that a Medisave Plan be linked to the purchase of a health insurance policy with a deductible of at least $1,800 ($3,600 for family). The cost of the health insurance policy and contributions to the Medisave Account are tax deductible.

3. Gives individuals the incentive to control health care spending by accumulating the Medisave Account to pay for medical services.

4. Allows amounts in the Medisave Account to accumulate from year to year. Interest accrued is not considered taxable income.

5. Allows employers to contribute to a catastrophic plan integrated with a Medisave Account similarly to the way they do for employer-provided health plans today.

SUBTITLE D: ANTI-FRAUD

PURPOSE: To strengthen the penalties for fraud in health care services.

This section:

1. Includes private mail carriers in the Federal mail fraud statute.

2. Allows for the forfeiture of property either involved in the health care fraud scheme or obtained with the proceeds of the scheme (post conviction).

3. Requires the payment of restitution including 3rd party payers and beneficiaries.

4. Increases funding for the HHS Office of Inspector General and FBI to detect and investigate health care fraud. Increases funding to the Department of Justice to develop a health care fraud unit to improve prosecutions of health care fraud cases. Funded through provision #5.

5. Fines and civil monetary penalties collected put into trust fund established to assist funding for health care fraud unit and investigations and prosecutions.

6. Provides whistle blower protection and reward if information leads to prosecution for health care fraud (additional discretionary authority to the Attorney General -- qui tam suits remain in place).

7. Enables all payers to use Medicare antifraud provisions to protect their beneficiaries from fraudulent activity.

8. Allows for imprisonment when an individual knowingly and willfully engages in a fraudulent act that results in serious injury to a patient. (Pending)

SUBTITLE E: MEDICARE PAYMENT CHANGES

PURPOSE: To allow more Medicare beneficiaries to participate in health maintenance organizations and other managed care arrangements.

This section:

1. Eliminates the current requirement that HMOs which serve Medicare patients have a membership that is no more than 50 percent Medicare and/or Medicaid beneficiaries.

2. Expands existing law to allow managed care networks (HMOs and PPOs) to provide Medigap benefits to Medicare beneficiaries in all 50 states on a permanent basis.

3. Directs the Secretary of Health and Human Services to consolidate the administration of Medicare Part A (Hospital Insurance) and Part B (Supplementary Medical Insurance) over a five-year period.

SUBTITLE F: REMOVING ANTITRUST IMPEDIMENTS

PURPOSE: To provide communities an opportunity to coordinate regionally the delivery of health care by exempting such activities from certain antitrust constraints.

This provision:

1. Provides a "limited exemption" from antitrust laws for all providers entering into joint ventures using a notification and pre-clearance process. Liability for providers entering into joint ventures and fulfilling the notification and pre-clearance requirements would be limited to actual damages. (Eliminates treble damages)

2. Provides a complete antitrust exemption for all providers entering into joint ventures that meet criteria developed by Secretary of HHS and Attorney General that demonstrate greater efficiencies, expanded access, reduced costs and elimination of excess capacity, associated with shared high technology equipment, medical services, or ancillary services. Exemption can be repealed if conditions under which complete exemption was granted change.

SUBTITLE G: ENCOURAGING ENFORCEMENT ACTIVITIES OF MEDICAL SELF-REGULATORY ENTITIES

PURPOSE: To reduce medical costs and improve quality by enabling physicians and other health care professionals to police themselves.

This section:

1. Limits the economic liability of professional self-regulatory bodies when engaged in standard setting and enforcement activities which are designed to promote the quality of medical care but which are not conducted for purposes of financial gain.

2. Allows for the courts to award that a plaintiff pay the legal fees of a substantially prevailing defendant in certain antitrust suits relating to standard setting and enforcement activities.

3. Requires federal agencies to consult with appropriate professional self-regulatory bodies in carrying out standard setting or other regulatory activities.

TITLE III: LONG TERM CARE

PURPOSE: To enable the elderly to use savings to buy long term care insurance products, and to purchase home nursing care.

This section:

1. Allows individuals to save for long term care by providing tax-favored treatment to qualified long term care insurance policies. Also it permits permanent life insurance, 401(k) and IRA savings to be used to pay for longer care and to be excluded from taxable income.

2. Allows States to offer seniors access to an asset protection plans, and allow States a choice in the amount of asset protection they offer.

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BIOGRAPHICAL SKETCH - CONGRESSMAN J. DENNIS HASTERT, R-IL-14

After having taught government and history for 16 years at Yorkville (Il.) High School, Congressman J. Dennis Hastert is now playing a role in both as a member of the 103rd Congress.

Congressman Hastert, 51, was elected in 1986 to represent the 14th Congressional District of Illinois, a suburban landscape of high tech firms, small and large industrial complexes and expansive farm land.

He is a member of the powerful Energy and Commerce Committee, which reviews nearly sixty percent of all the legislation that eventually reaches the floor of the House. The committee's jurisdiction includes energy policy, interstate and foreign commerce and trade, broadcast and telecommunications policy, food health and drug issues. In 1991, Hastert was asked by Bob Michel, the Republican Leader, to serve on his Party's task force on Health Care Reform - a role which recently led Michel to appoint Hastert as the House Republican representative on the new White House Health Care Reform Task Force, chaired by First Lady Hillary Rodham Clinton.

Hastert serves on the Health and Environment, Energy and Power and Telecommunications and Finance Subcommittees.

His second committee assignment is on the Government Operations Committee, where he serves as the ranking member of the Environment, Energy and Natural Resources Subcommittee. Hastert's service on the Government Operations Committee provides him with opportunities to bring both economy and efficiency to the federal bureaucracy, and also allows oversight into agencies as varied as the Environmental Protection Agency, Nuclear Regulatory Commission and U.S. Army Corps of Engineers.

Rep. J. Dennis Hastert

He was also honored this year by his fellow House Republicans with an appointment to the post of Deputy Minority Whip.

During his years in Congress, Hastert has pushed legislation to reform the budget process, balance the federal budget and cut government waste. He has also led a nationwide fight to repeal the unfair Social Security Earnings Test, which discriminates against seniors who choose to continue working after they reach retirement age.

Concerned about the environment, Hastert has led the fight to defeat a massive experimental balefill/landfill proposed for the northern part of his district. He has also worked for the removal and proper disposal of eleven million cubic feet of low level thorium waste currently sitting in West Chicago, Illinois.

Hastert has enjoyed strong editorial support from the newspapers in his district, and he has been the recipient of the "Outstanding Legislator" award by numerous groups. He is particularly proud to have been named a Friend of Agriculture and to have won the Golden Bulldog Award in each of his years in Congress for fighting against waste in government.

Prior to his election to Congress, Hastert served three terms in the Illinois General Assembly, where he spearheaded legislation on child abuse prevention, property tax reform, educational excellence and economic development.

He is a 1964 graduate of Wheaton (IL) College and earned his master's degree from Northern Illinois University at DeKalb in 1967. He is married to the former Jean Kahl and they are parents of two teenage sons, Joshua and Ethan. The family resides in Yorkville.

SUMMARY: THE AFFORDABLE HEALTH CARE NOW ACT OF 1993

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2. Encourages employers to facilitate employee enrollment in health plans through multiple employer purchasing arrangements or state-sponsored accessible health benefit systems.

3. Limits preexisting condition restrictions under all employer health benefit plans, including self-funded plans. Eliminates pregnancy as a preexisting medical condition and provides coverage for newborns at birth.

4. Ends job-lock by assuring continuous availability of health coverage by prohibiting preexisting condition restrictions for those who are continuously covered.

5. Prohibits employer health plans from being canceled or denied renewability except for the following reasons: (a) nonpayment of premiums, (b) fraud or misrepresentation, and (c) noncompliance with plan provisions.

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PURPOSE: To provide the self-employed with tax treatment for the purchase of health insurance equal to that of other Americans who now receive a tax exclusion for employer-paid health benefits.

This section:

1. Gradually increases the current law tax deduction for cost of health premiums for the self-employed from 25% to 100%. (Cost $4.7 billion over 5 years; a Medicare payment change per Title II, Subtitle F, imposing a 10% co-insurance requirement for clinical laboratory services on Medicare beneficiaries provides sufficient savings to offset any revenue loss due to this provision.)

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PURPOSE: To expand capacity of communities to meet the health care needs of their citizens, especially lower income and uninsured individuals through expanding the number of community and migrant health care programs and the resources available to them.

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1. Permits existing rural community hospitals participating in the Medicare program, to maintain their Medicare status as a rural community hospital after meeting criteria of eligibility as a rural emergency access care hospital.

SUBTITLE G: STATE FLEXIBILITY IN THE MEDICAID PROGRAM: THE MEDICAL HEALTH ALLOWANCE PROGRAM

PURPOSE: To allow states to develop guaranteed access to health insurance for the entire state population. States will be provided more flexibility and allowed to extend Medicaid to cover more of the uninsured while working with the private sector to bridge the gap between Medicaid and employer-provided insurance.

This section:

1. Allows States to redirect Medicaid funds into Health Allowance Programs where eligible individuals will be able to enroll in private-market health plans.

2. Provides States with the option of increasing eligibility to the Health Allowance Program up to 100% of the Federal Poverty Level.

3. Provides States with the option of setting up a sliding scale subsidy whereby individuals up to 200% of the Federal Poverty Level could buy-in to the Health Allowance Program.

4. Allows States to develop pooling mechanisms so that all other families and individuals without insurance (part-time workers, early retirees, etc.) can join Accessible Health Benefit Systems for the purpose of buying health insurance.

SUBTITLE H: MEDICAID PROGRAM FLEXIBILITY

PURPOSE: To give states more flexibility to enroll Medicaid beneficiaries in HMOs and PPOs. Under current Federal law if a State wants to require Medicaid recipients to enroll in health maintenance organizations (HMOs), it must submit a waiver application to the Health Care Financing Organization (HCFA). These waiver applications are granted for only a limited period of time and cannot be renewed. These procedures have greatly limited the ability of States to enroll Medicaid beneficiaries on HMOs.

This provision:

1. Allows States to enroll Medicaid beneficiaries in HMOs and PPOs without having to submit cumbersome waiver applications. States would be given the option to mandatorily enroll Medicaid beneficiaries provided they meet Federal quality assurance standards.

TITLE II: HEALTH CARE COST CONTAINMENT AND QUALITY ENHANCEMENT

SUBTITLE A: MEDICAL MALPRACTICE LIABILITY REFORM

PART 1: Medical malpractice and product liability reform

PURPOSE: To improve access to fair compensation for those injured while receiving medical care and to increase the availability of health care services by reducing the costs of both medical malpractice liability premiums and defensive medicine.

This section:

1. Initiates Federal reform of medical malpractice liability actions by linking federal dollars to malpractice reform initiatives.

2. Requires that health care liability action include, in addition to health care providers and professionals, medical product producers. Medical products mean both drugs and devices as defined in the Federal Food, Drug, and Cosmetic Act by the Food and Drug Administration (FDA). That punitive damages relating to medical product liability not be awarded against a medical product producer if the drug or device was subject to approval by the FDA or generally recognized as safe and effective as established by the Federal Food, Drug, and Cosmetic Act, except in the case of withheld information, misrepresentation, or illegal payment.

3. Requires all medical liability disputes in a state to be initially resolved by a dispute resolution process prior to entering the court system as a condition of the receipt of federal funds under federal health related programs, including tax deductibility of health insurance expenses.

4. Places a $250,000 cap on non-economic damages. (Punitive damages are handled separately.)

5. Directs that punitive damages awarded by courts be paid to States to assist in funding their efforts to reduce medical malpractice. Includes a definition of punitive damages as compensation over and above the actual harm suffered, awarded for the purpose of punishing a person for conduct deemed to be malicious, wanton, willful, or excessively reckless.

6. Allows for structured periodic payment of compensatory awards.

7. Places limits on attorneys' contingency fees.

8. Limits the liability of the defendant to his/her proportion of negligence.

9. Sets a uniform statute of limitations for plaintiffs of all ages.

10. Clarifies a uniform standard for determining that a defendant has acted negligently.

11. Imposes a higher standard of proof for liability associated with certain obstetric services.

12. Discourages frivolous court actions by requiring the plaintiff to pay the defendant's legal fees, if the plaintiff loses.

13. Allows Federal and State courts to determine a fee bond amount based on a reasonable determination of anticipated court costs and includes the use of certain property in lieu of bond.

PART 2: Requirements For State Alternative Dispute Resolution Systems (ADR)

PURPOSE: To permit the Secretary of HHS (in consultation with the Attorney General) to be able to certify the States' alternative dispute resolution systems.

This section:

1. Establishes basic requirements for ADR. It requires the Secretary to report to Congress within 5 years about the effects of State ADR systems on cost, access, and quality of health care.

SUBTITLE B: ADMINISTRATIVE COST SAVINGS

PURPOSE: To reduce the administrative cost of our health care system by streamlining the insurance billing system and utilizing the latest technological innovations in information processing.

PART 1: Standardization of Claims Processing

PURPOSE: To simplify payment for medical services; eliminate unnecessary overhead and administrative cost; reduce billing fraud and abuse; improve the collection of clinical information for research; and improve health care quality.

This section:

1. Mandates the Secretary of Health and Human Services (HHS) to develop a standard claims form and data set for electronic transmission of health coverage information and billing data.

2. Requires the Secretary of HHS to set standards for the use of magnetized Medicare cards and issue them to beneficiaries.

3. Requires hospitals, physicians and carriers to conform to the uniform claims reporting standards.

4. Requires the Secretary of HHS to design a clearinghouse for primary and secondary payor information for the working aged and other Medicare beneficiaries who may have employer-provided coverage.

5. Requires use of the Social Security number as the identifier for all medical claims.

6. Provides protection for individual privacy regarding claims and medical records.

7. Overrides state laws which prevent the sole use of electronically transmitted claims and other medical records for payment purposes.

PART 2: Electronic Medical Data Standards

PURPOSE: To improve quality of patient care by assuring the development of more usable medical records.

This section:

1. Requires all hospitals to put in place an electronic patient care information system by January 1, 1996, which meets standards set by the Secretary.

PART 3: Development and Distribution of Comparative Value Information

PURPOSE: To provide consumers information necessary for cost and quality conscious purchasing of medical services.

This section:

1. Requires states to make available to consumers information on the comparative value of medical services.

SUBTITLE C: MEDICAL SAVINGS ACCOUNTS (MEDISAVE)

PURPOSE: To provide incentives for health care cost consciousness and allow any savings to accrue to the individual and family through the use of Medical Savings Accounts.

This section:

1. Allows tax-free deposits to Medisave Accounts to reimburse medical expenses and pay for long-term care, catastrophic, Medigap, and Medicare premiums.

2. Requires that a Medisave Plan be linked to the purchase of a health insurance policy with a deductible of at least $1,800 ($3,600 for family). The cost of the health insurance policy and contributions to the Medisave Account are tax deductible.

3. Gives individuals the incentive to control health care spending by accumulating the Medisave Account to pay for medical services.

4. Allows amounts in the Medisave Account to accumulate from year to year. Interest accrued is not considered taxable income.

5. Allows employers to contribute to a catastrophic plan integrated with a Medisave Account similarly to the way they do for employer-provided health plans today.

SUBTITLE D: ANTI-FRAUD

PURPOSE: To strengthen the penalties for fraud in health care services.

This section:

1. Includes private mail carriers in the Federal mail fraud statute.

2. Allows for the forfeiture of property either involved in the health care fraud scheme or obtained with the proceeds of the scheme (post conviction).

3. Requires the payment of restitution including 3rd party payers and beneficiaries.

4. Increases funding for the HHS Office of Inspector General and FBI to detect and investigate health care fraud. Increases funding to the Department of Justice to develop a health care fraud unit to improve prosecutions of health care fraud cases. Funded through provision #5.

5. Fines and civil monetary penalties collected put into trust fund established to assist funding for health care fraud unit and investigations and prosecutions.

6. Provides whistle blower protection and reward if information leads to prosecution for health care fraud (additional discretionary authority to the Attorney General -- qui tam suits remain in place).

7. Enables all payers to use Medicare antifraud provisions to protect their beneficiaries from fraudulent activity.

8. Allows for imprisonment when an individual knowingly and willfully engages in a fraudulent act that results in serious injury to a patient. (Pending)

SUBTITLE E: MEDICARE PAYMENT CHANGES

PURPOSE: To allow more Medicare beneficiaries to participate in health maintenance organizations and other managed care arrangements.

This section:

1. Eliminates the current requirement that HMOs which serve Medicare patients have a membership that is no more than 50 percent Medicare and/or Medicaid beneficiaries.

2. Expands existing law to allow managed care networks (HMOs and PPOs) to provide Medigap benefits to Medicare beneficiaries in all 50 states on a permanent basis.

3. Directs the Secretary of Health and Human Services to consolidate the administration of Medicare Part A (Hospital Insurance) and Part B (Supplementary Medical Insurance) over a five-year period.

SUBTITLE F: REMOVING ANTITRUST IMPEDIMENTS

PURPOSE: To provide communities an opportunity to coordinate regionally the delivery of health care by exempting such activities from certain antitrust constraints.

This provision:

1. Provides a "limited exemption" from antitrust laws for all providers entering into joint ventures using a notification and pre-clearance process. Liability for providers entering into joint ventures and fulfilling the notification and pre-clearance requirements would be limited to actual damages. (Eliminates treble damages)

2. Provides a complete antitrust exemption for all providers entering into joint ventures that meet criteria developed by Secretary of HHS and Attorney General that demonstrate greater efficiencies, expanded access, reduced costs and elimination of excess capacity, associated with shared high technology equipment, medical services, or ancillary services. Exemption can be repealed if conditions under which complete exemption was granted change.

SUBTITLE G: ENCOURAGING ENFORCEMENT ACTIVITIES OF MEDICAL SELF-REGULATORY ENTITIES

PURPOSE: To reduce medical costs and improve quality by enabling physicians and other health care professionals to police themselves.

This section:

1. Limits the economic liability of professional self-regulatory bodies when engaged in standard setting and enforcement activities which are designed to promote the quality of medical care but which are not conducted for purposes of financial gain.

2. Allows for the courts to award that a plaintiff pay the legal fees of a substantially prevailing defendant in certain antitrust suits relating to standard setting and enforcement activities.

3. Requires federal agencies to consult with appropriate professional self-regulatory bodies in carrying out standard setting or other regulatory activities.

TITLE III: LONG TERM CARE

PURPOSE: To enable the elderly to use savings to buy long term care insurance products, and to purchase home nursing care.

This section:

1. Allows individuals to save for long term care by providing tax-favored treatment to qualified long term care insurance policies. Also it permits permanent life insurance, 401(k) and IRA savings to be used to pay for longer care and to be excluded from taxable income.

2. Allows States to offer seniors access to an asset protection plans, and allow States a choice in the amount of asset protection they offer.

AFFORDABLE HEALTH CARE NOW ACT - CORNERSTONE FOR REFORM

- Health care reform, in order to be truly effective, must be built on what works. As such, it must be undertaken in stages, with ideas being tried and tested in a variety of settings in order to avoid any adverse impact on the nation as a whole should they fail.

- Imposing an untried scheme nationwide, developed behind closed doors (the Clinton proposal), entails excessive risks to health care in America. It is an all or nothing approach which, because it has not been tested, has greater potential for creating chaos than it does for making things better.

- The Affordable Health Care Now Act proposes an initial stage of significant reforms which will help establish a solid foundation for our new health care system. They are reforms which can and should be enacted this year.

- These reforms, undertaken in partnership with state governments and the private sector, will bring about early progress in both cost containment and increased insurance coverage. They will also pave the way for further reforms in subsequent stages by effectively determining what works and what does not work.

- The bill substantially expands the availability of health insurance to the uninsured. It insures that all employees have access to lower cost group health insurance by requiring that all employers must offer, though not necessarily pay for, insurance to their employees, and requiring that insurance companies must make insurance available to small businesses. The bill thus also insures the availability of insurance for those who change jobs, and protects those with serious illness from insurance loss or excessive premium increases.

- It removes impediments that restrict the ability of small businesses to group together to provide their employees lower cost health insurance, and provides the self-employed and others who purchase their own insurance a 100% tax deduction.

- The bill also provides for a new Medisave program, which allows employees to set money aside, tax-free, to use for medical expenses.

- The bill enables us to make early progress on the cost containment front through malpractice reform and administrative streamlining that reduces paperwork, moves toward electronic billing, and removes anti-trust restrictions on cooperation among providers.

- Finally, the bill makes it easier for states to undertake their own health care reforms by giving them greater flexibility to administer their Medicaid programs, including the option to use private insurance for Medicaid beneficiaries and to permit uninsured people to buy-in to the program.

AFFORDABLE HEALTH CARE NOW ACT

Improved Access to Affordable Health Care Coverage

I. All employers must offer, but are not required to pay for, insurance to their employees

II. Small group insurance reform

- A. Insurers must offer small employers standard and catastrophic plans within an actuarial value range as determined by the National Association of Insurance Commissioners. They may also offer a Medisave Plan.
- B. Small group is defined as employers with between 2-50 employees.
- C. Risk pools would be established to spread insurer risks.

III. Employee Insurance Security

- A. Employees cannot be excluded from insurance coverage because of pre-existing conditions.
- B. Employees are assured of continued insurance coverage when changing jobs.

IV. Promoting More Affordable Insurance Coverage

- A. Increase tax deductions for the self-employed to 100% and provide deductions for employees who purchase their own insurance.
- B. Exempt all group health plans from state benefit mandates.
- C. Prohibit state restrictions on managed care.
- D. Establish standards and incentives for multi-employer insurance purchasing groups.
- E. Eliminate current IRS regulatory barriers which prevent employer groups from being able to offer tax-exempt health insurance.

V. Family Medical Savings Accounts (Medisave)

VI. Reforming Medicaid

- A. Permit states to utilize private insurance for Medicaid beneficiaries.
- B. Permit uninsured people to buy-in to the Medicaid program, with graduated subsidies up to 200% of poverty.

VII. Expansion of Community Health Center Program

VIII. Expanded Rural Health Care Services

IX. Long-term Care

Health Care Cost Containment

I. Malpractice Reform

II. Administrative Reform

- A. Streamlined Paperwork
- B. Electronic Billing
- C. Merge Medicare Parts A and B

III. Anti-trust Reforms

IV. Anti-fraud provisions

V. State Medicaid flexibility

U.S. HOUSE OF REPRESENTATIVES
103rd Congress

September 15, 1993

Pursuant to Clause 4 of rule XXII of the rules of the House of Representatives, the following sponsors are hereby added to:

The Affordable Health Care Now Act of 1993

Bob Michel
Newt Gingrich
Wayne Allard
Bill Archer
Dick Armey
Spencer Bachus
Richard Baker
Cass Ballenger
Bill Barrett
Roscoe Bartlett
Joe Barton
Helen Bentley
Mike Bilirakis
Tom Bliley
Sherwood Boehlert
John Boehner
Henry Bonilla
Jim Bunning
Dan Burton
Steve Buyer
Dave Camp
Mike Castle
Bill Clinger
Mac Collins
Phil Crane
Duke Cunningham
Tom Delay
Bill Emerson
Tom Ewing
Harris Fawell
Tillie Fowler
Gary Franks
Elton Gallegly
Dean Gallo
George Gekas
Wayne Gilchrest
Ben Gilman
Paul Gillmor
Bill Goodling
Porter Goss
Fred Grandy
Steve Gunderson
Mel Hancock
Dennis Hastert
Joel Hefley
Wally Herger
Dave Hobson
Martin Hoke
Duncan Hunter
Tim Hutchinson
Henry Hyde
Bob Inglis
Jim Inhofe
Nancy Johnson
John Kasich
Jack Kingston
Joe Knollenberg
Jim Kolbe
Jon Kyl
Dave Levy
Jerry Lewis
Tom Lewis
Jim Lightfoot
John Linder
Joe McDade
John McHugh
Bill McCollum
Buck McKeon
Alex McMillan
Donald Manzullo
Jan Meyers
Dan Miller
Carlos Moorhead
John Myers
Jim Nussle
Mike Oxley
Ron Packard
John Paxon
Tom Petri
Rob Portman
Deborah Pryce
Jack Quinn
Ralph Regula
Pat Roberts
Marge Roukema
Rick Santorum
Dan Schaefer
Jim Sensenbrenner
Clay Shaw
Chris Shays
Joe Skeen
Chris Smith
Nick Smith
Olympia Snowe
Jerry Solomon
Bob Stump
Jim Talent
Bill Thomas
Craig Thomas
Fred Upton
Barbara Vucanovich
Bob Walker
Jim Walsh
Frank Wolf
Don Young
Bill Zeliff

States to help fund efforts to reduce medical malpractice, and places limits on attorney's contingency fees.

** Action '93 will limit the liability of medical products and drugs which have been approved or are recognized as safe and effective, and of certain obstetric services.

** Action '93 allows for periodic payment of compensatory awards and limits liability of a defendant to their involvement in the negligent act.

** Action '93 establishes a uniform statute of limitations and clarifies a uniform standard for determining negligence.

** Action '93 allows Federal and State courts to require a defendant to purchase a bond to cover court costs.

Administrative Reforms:

** Action '93 will require the use of a uniform billing form.

** Action '93 will eliminate barriers to and encourages the use of electronic billing systems.

Removing Anti-Trust Impediments:

** Action '93 will provide communities an opportunity to coordinate the delivery of health care regionally by exempting such activities from certain antitrust constraints.

** Action '93 will provide a "limited exemption" from antitrust laws for all providers entering into joint ventures using a notification and pre-clearance process.

** Action '93 also provides a complete antitrust exemption for all providers entering into joint ventures that meet criteria developed by the Secretary of HHS and the Attorney General that demonstrate greater efficiencies, expand access, reduce costs and elimination of excess capacity, associated with shared high technology equipment, medical services, or ancillary services.

Eradicating Fraud and Abuse:

** Action '93 strengthens the penalties for fraud in health care services. For example, Action '93 allows for the forfeiture of property either involved in the health care fraud scheme, or obtained with the proceeds of the scheme. Action '93 also provides for fines and civil monetary penalties collected to be put into a trust fund established to assist funding for a health care fraud unit and for investigations and prosecutions.

Eliminating State Mandates:

** Action '93 will preempt state mandates on basic health care plans and state restrictions on managed care programs.

** Action '93 bridges the gap for low-income workers and early retirees by allowing States to establish group insurance plans and make them available for purchase.

Promoting Tax Fairness:

** Action '93 provides 100% tax deductibility of the cost of health insurance premiums to individuals now lacking coverage.

** Action '93 increases the tax deduction for the self-employed from the current 25% to 100%, giving the self-employed the same tax advantage as other employers.

Expanding Access in Underserved Areas:

** Action '93 expands the Community Health Center program by increasing the authorization for Community and Migrant Health Centers $1.5 billion over 5 years.

** Action '93 expands rural health care services through enhanced rural emergency medical service assistance, rural air transport systems assistance and the extension of special treatment rules for Medicare dependent, small rural hospitals.

** Action '93 establishes a Rural Emergency Access Care Hospitals (REACHs) program for the purpose of providing 24 hour emergency care in rural areas.

SECURITY

Eliminating the Fear of Losing Coverage:

** Action '93 limits preexisting condition restrictions under all employer plans, including self-funded plans.

** Action '93 ends "job-lock" by assuring continuous availability of coverage through an employer, and by prohibiting preexisting condition restrictions for those who are continuously covered.

** Action '93 prohibits employer health plans from being cancelled or denied renewability.

Securing the Future by Expanding Long Term Care:

** Action '93 will provide the same tax benefit for long term care insurance as for other health insurance plans.

** Action '93 allows Americans the option of using IRAs, 401(k) plans, or life insurance -- tax free -- to purchase long term care insurance.

** Action '93 allows States to offer seniors asset protection plans to encourage purchasing of long term care insurance.

CONTROLLING THE GROWTH OF HEALTH CARE COSTS

Malpractice/Product Liability Reform:

** Action '93 will require all disputes to be initially resolved by an alternative dispute resolution system. Also requires plaintiffs to pay defendant's legal fees if the plaintiff rejects the ADR decision, goes to court and does not receive higher awards.

** Action '93 caps non-economic damages, directs that punitive damages be paid to the

THE AFFORDABLE HEALTH CARE NOW ACT OF 1993

ACCESS -- The Road to Universal Coverage

Increasing Employee Access to Coverage:

** Action '93 will require that all employers offer a basic insurance plan to their employees.

** Action '93 will encourage and make it possible for employers to obtain affordable health coverage through group purchasing arrangements.

** Action '93 will require insurers who sell in the small group market to offer health plans, including a Standard Plan, a Catastrophic Plan, and a Medisave Plan, to all companies who employ 2 to 50 employees. These plans must meet a minimum coverage level as determined by the National Association of Insurance Commissioners.

** Action '93 will limit the insurance premium rate variations charged to small businesses and will limit the annual increases in insurance premium rates.

** Action '93 will encourage group purchasing arrangements by easing paperwork and other regulatory burdens and by eliminating the current IRS regulatory barriers which prevent employer groups (the American Farm Bureau, for example) from being able to offer health insurance.

Family Medical Savings Accounts:

** Action '93 will allow and encourage the creation of personal medical savings accounts (Medisave). Action '93 allows for equitable tax treatment of Medisave accounts for the purchase of catastrophic health insurance and an "out-of-pocket" health care expenses account.

** Action '93 requires employees who choose a Medisave plan to purchase a health insurance policy with a deductible of at least $1,800 ($3,600 for families). The cost of the health insurance policy and contributions to the Medisave Account are tax deductible. The maximum contribution to the Medisave Account is limited to the policy's deductible or $2,500 for individuals ($5,000 for families).

** Action '93 allows individuals to control their own health care spending by using the Medisave Account to pay for medical services. Amounts used for non-medical services are subject to tax plus a 20% penalty. Non-medical withdrawals which would reduce the account balance below the policy deductible are subject to a 50% penalty.

** Action '93 allows the balance in the Medisave Account to accumulate from year to year. Interest accrued will <u>not</u> be considered taxable income.

Medicaid Reform:

** Action '93 allows States to use certain Medicaid funds to purchase health plans and provide subsidies to people with incomes up to 200% of poverty.

** Action '93 streamlines the Medicaid waiver process by allowing States to place all Medicaid beneficiaries in managed care plans.