Preliminary Summary of Proposed Plan

September 9, 1993

Coverage

* All citizens and legal residents would be guaranteed health insurance coverage and a Federally guaranteed benefit plan, and all such individuals up to age 65 would receive coverage through their alliance

* By January 1, 1997, each state must establish one or more regional health alliances for its residents

  -- It is envisioned that as many as 10 States could be operational by 1995

* All workers are required to obtain coverage through the health alliance where they live or though a corporate alliance.

* In general, all other individuals, including the self-employed and unemployed, will also get coverage through the regional alliance unless they qualify for Medicare

* Undocumented workers would not be eligible for guaranteed health benefits; however, employers would be required to pay for all employees regardless of immigration status

* Retirees between ages 55 to 64 would receive coverage through the alliance, and would be responsible for 20% of the premium; the Federal government would assume 80% of premium costs (@ $14 b /year)

  -- For retirees with guaranteed benefits from a company, the company would assume the employee's share

* Coverage for current Medicaid acute care beneficiaries would be modified

  -- Under 65 Medicaid beneficiaries who are not receiving AFDC or SSI cash payments will no longer receive Medicaid; they will enter alliances as other individuals, based upon employment

  -- Medicaid continues for AFDC and SSI beneficiaries, with Medicaid paying alliances a capitated rate for services covered under the national defined benefit package

- Recipients choose among plans in alliance; if they choose a plan at or under the weighted average premium, no additional payments for premiums are required

- Medicaid would continue to pay for other benefits for cash recipients, as under current law

* Coverage during transitional period: Secretary of HHS would be authorized to establish a national risk pool to make health insurance available on an interim basis

  -- Secretary would contract with private insurers

  -- Enrollment in risk pool would be voluntary

  -- Assessments would be imposed on all insurers to support the pool, including assessments on self-funded plan

Employment-Based Coverage

* The Secretary of Labor ensures that all employers fulfill the obligation to make contributions or provide coverage through a qualified health plan

* Coverage for all workers would be achieved through mandated contributions from all employers and employees

* All employers (except those with 5,000+ employees) would be required to make contributions to the regional pool

  -- Employers would be required to pay 80% of the average premium across all alliance plans

    - Employers could pay part or all of the employee's share

  -- Small employers' share of premium would be capped at 7.9 percent of payroll

  -- Sliding scale subsidies would be available to employers with 50 or fewer employees, if their average wage is less than $24,000/year. Firms with an average wage less than $12,000/year would have contribution capped at 3.5% of payroll.

* Individual employees would be required to pay the difference between the employer contribution and the plan's actual premium -- for the average cost plan, this would be 20 percent of the premium

-- In small firms, individual premiums capped at 1.9 percent of payroll

-- Subsidies would be available to families with incomes up to 150 percent of the official poverty level (up to $21,514 for a family of four) to help pay for premiums, and up to 250% of poverty for subsidies for deductibles and coinsurance

- Subsidy levels would be set to cover up to 20% of the premium for the average cost plan

-- A separate system of subsidies would be available to individuals employed by corporate alliances

* Subsidies for low income individuals would be an entitlement, and would be funded by Federal general revenues

* Self-employed and those with unearned income would pay premium based upon a fixed percent of income

Corporate Alliances"(5,000+ employees/Taft Hartley plans)

* The Department of Labor regulates employers and corporate alliances

* Firms with 5,000 or more employees would be able to buy health coverage directly from the health plans, bypassing the alliance

* Firms would be required to offer employees at least 3 coverage options, including the firm's own health plan

* Employees in corporate alliances would not be eligible for the general public subsidy, but would be subsidized under an alternative system

-- The employer contribution for employees enrolled in a corporate alliance earning less than $15,000 would be the greater of 80% of the average premium or 95% of the lowest-cost plan offered by the corporate alliance.

* Corporate alliances would have to comply with cost containment goals set by the National Health Board

* Large employers that exceed spending targets would lose the privilege of running their own health plans and would be required to purchase coverage through regional alliances

* Taft-Hartley plans and firms with 5,000 or more employees *would be permitted* to participate in the regional alliance, but only "if they participate at an experience rate" for a period of time.

* Taft-Hartley plans and employers with 5,000 or more employees that do not participate in the regional alliance must offer employees a choice of plans and ensure compliance with standards

* <u>Cost Containment</u>

  * No short-term cost-containment

  * Limits on Medicare and Medicaid spending beginning in fiscal 1996

    -- **Medicare savings of $124 b over 1996-2000**

       - Through a variety of specified Medicare savings provisions (see below)

    -- **Medicaid savings of $114 b over 1996-2000**

       - Achieved by a cap on spending

  * For private sector, the plan would cap the amount that health premiums can rise in each year

    -- Premiums would be limited to the same rate as the annual growth in the CPI by 1997

  * The National Health Board would determine the cost of the standard benefit package and would calculate the national per capita premium needed to cover the cost

    -- The per capita premium would be adjusted for regional variations in health spending

  * The National Board would set a per capita premium target for each of the health insurance purchasing groups set up across the country -- effectively setting a yearly budget for each alliance

  * The National Board would adjust premium targets to reflect each Alliance's population characteristics (age, gender, health status) and historical costs relative to the national average

  * If the average premium within an Alliance exceeds the target, the Alliance could:

    -- Freeze enrollment in high cost plans

-- Assess plans with excess premiums an amount equal to amount by which premium exceeds target

- Plans subject to assessment could automatically assess providers an equal amount through reductions in payment rates

* If an Alliance fails to limit growth in premiums, the National Board may decertify the Alliance and require the State to establish new Alliances

* If a State fails in its obligations, the Secretary of the Health and Human Services could establish a Federal system for assuring residents in a State with health insurance (see below)

Revenue/Funding Sources:

* **Cigarette tax: $1 per pack ($105 b over 6 years)**

-- Possible tax on hard alcohol could substitute for some of these revenues

* Medicare: $124 b over 1996 -2000

-- Variety of reconciliation type cuts

-- Level of cuts is based on assumed "budget" that slows growth in Medicare to CPI plus population by 2000

- Ultimate growth rate is slightly less than growth in GDP

-- Medicare cuts include:

- Reductions in hospital market basket
- Reduction in indirect teaching adjustment
- Reduction in capital payments
- Phasing down disproportionate share payments by 1998
- Reduce home health cost limits
- Further reduce MVPS defaults
- Reduce RB RVS update by 3% in 1996 with primary care held harmless
- Establish prospective payment system for hospital outpatient department radiology, surgery and diagnostic services

- Competitive contracting for clinical labs and 20% copayment for lab services

- Extend Medicare Secondary payer policies

- 10% coinsurance for home health visits more than 20 days following inpatient stay

- State and local employees required to pay HI tax

- Income relate Part B premium

* Medicaid savings of $114 billion by year 2000

  -- Some Medicaid savings are due to shift of low-income workers out of Medicaid and into employment-based system

  -- Other savings due to cap on Federal Medicaid payments, enforced beginning in 1996

* $51 b anticipated increase in income taxes attributable to employer savings from lower health care costs from 1996 through 2000

* $47 b in other unspecified Federal savings

Standard Benefits

* The standard benefit package would be defined initially in statute

* The National Board would review and update the standard benefit package

  -- The National Board would issue regulations, as necessary

* The standard benefit package would include benefits typically offered by employers, and would emphasize primary and preventive services

* Out-of-pocket costs

  -- FFS plan: deductible of $200 individual/$400 family; 20% coinsurance; stop-loss $1,500 individual/$3,000 family; separate deductibles for prescription drugs and mental health

  -- HMOs and other organized care plans would have lower cost-sharing (e.g. $10 per visit)

-- Combination, with higher cost-sharing for out-of-plan providers

* In general, additional coverage could be purchased by individuals or provided by employers with after-tax dollars

  -- Employers could pay the employee's share of premium without the payment being treated as taxable income to the employee

  -- Employers who provided benefits beyond the nationally guaranteed benefit package as of a date certain, could, under certain circumstances, continue to provide such benefits with favorable tax treatment

* Balance billing above the Alliance established fee schedules or payments would be prohibited

National Administration

* National Board reviews plans submitted by States

* Department of Labor supervises corporate alliances

* "In the event that a states fails to meet the deadline for establishing regional health alliance system, the Board ensures that all individuals have access to services covered in the guaranteed benefit package"

* "To induce a state to act, the Board informs the Secretary of HHS of the State's failure to comply. The Secretary has the authority to order withholding of federal health appropriations".

* If the State continues to fail, the Secretary of HHS is required to

  -- establish one or more regional alliances in compliance with federal regulations; or

  -- contract with private parties or others to establish regional alliances; or

  -- order regional alliances or plans to comply with specific federal requirements

* If a State fails to comply, the Secretary of the Treasury shall impose a payroll tax on all employers in that States. The tax will be sufficient to allow the Federal government to provide health coverage to all individuals in the state and to reimburse the Federal government for the cost of monitoring and operating the system

National Health Board

* Seven members appointed by the President with the advice and consent of the Senate. At least one member must represent interests of States.

* The Board establishes requirements for state plans, monitors compliance with requirements, provides technical assistance and "ensures access to health care for all Americans"

* The Board interprets and updates the nationally guaranteed benefit package and issues regulations. The Board may recommend changes to the President and the Congress regarding the benefit package

* The Board issues regulations concerning implementation of the national budget for health spending and enforces the budget

  -- Establishes baseline budget for alliances

  -- Certifies compliance with budget

* The Board develops a risk adjustment system to be used by the alliances

  -- If the National Board determines that even with the risk adjustment system, plans that serve disproportionately large numbers of AFDC and SSI enrollees are adversely affected, the Board creates a payment system to shift funds across plans to equalize the effects

* The Board established and manages a performance based system of quality management and improvement, and develops and implements standards for a National Health Information System

* The Board is authorized to make adjustments as necessary in the amounts required of individual States so long as the total maintenance effort for Medicaid remains constant

  -- The Board may increase payments for "low effort states"

* The Board establishes a Breakthrough Drug Committee, with the "authority to make public declarations regarding reasonableness of launch prices" of new drugs.

* The National Board will assess the extent to which plans are capable of providing high quality care to disabled (Medicaid) persons. If the Board decides that access to freedom of choice plans is not necessary to assure high quality care for the disabled, then additional premium and cost-sharing subsidies allowed under plan will be phased out

State Responsibilities

* State submits plan to National Board for review

* Plan submitted must state how State intends to administer subsidies to low income individuals and employers; conduct review of financial solvency of plans, collect data, monitor quality, establish standards for governance of alliance, including mechanism for selecting members of the board

* States approve all health plans offered through regional alliances

* Operates a guaranty fund

* State plan may include establishment of single payer or all-payer systems

Health Alliances

* Department of Labor oversees financial operation of the alliance; DOL may recommend to Board if remedial action for alliance is required

* States would be required to establish one or more health alliance, with not more than one alliance in each area

* Alliances could be State agencies or non-profit organizations, directed by boards that include consumers, business, etc. (not providers)

* Alliances would have the primary responsibility of negotiating premiums with health plans

* Health alliances could not be segregated by race, income or health status

* Each alliance would include at least one FFS plan

-- Alliance and/or States would establish a fee schedules or payment rate for all providers in the FFS plan

- No extra-billing would be permitted

-- The FFS plan would be subject to overall per capita constraint

* Alliances would make risk-adjustments for high cost enrollees

-- Specifications for risk adjuster would be promulgated by the National Board

* Alliances would participate in federally established quality management and improvement program

* Alliances would ensure that all individuals enroll, that all plans provide minimum benefit package, provide information to consumers, meet quality standards

* Alliances and health plans would be required to contract with "safety net" providers

* Alliances may not cross State lines, but States may "coordinate operation of alliances".

Health Plans

* Health plans would contract with alliances, and would be subject to Federal standards including minimum benefits, enrollment practices, termination of coverage rules, etc.

* Premiums paid to health plans could not vary by category of enrollee

* Physicians would be permitted to join more than one health plan

* Plans would have to have consumer grievance and appeals procedures

* Plans must contract with "essential community providers" and academic medical centers

* Plans may be made up (or owned by) providers, or may contract with selected providers

-- Terms of agreements could be based on FFS, salary, or other basis

* Health plans would be subject to requirements established by State to protect against bankruptcy of health plans (guaranty fund)

* Interim insurance requirements would be enforced by States (until implementation of health alliances)

  -- Insurers would be required to maintain coverage in force;

  -- Insurers would be prohibited from varying premium increases among enrollees of individual and small group (less than 100 lives) plans; average premium increases for larger groups must equal premium increase applied to individual and small groups plans.

  -- Pre-existing condition exclusions could not be applied to individuals with prior coverage and could not extend beyond 6 months for newly insured individuals

  -- Insurers and ERISA plans could not apply caps on coverage if treatment costs exceed $5,000

Supplemental Insurance

* Supplemental insurance would be allowed

  -- Premiums paid for, and costs, of supplemental plans would not be included under cost containment system

* National Board would define 2 standard wrap-around policies

* National Board would establish additional standards to prohibit duplicate coverage, require 90% loss ratios, etc.

* Dread disease, hospital indemnity policies would not be subject to regulation

Federal programs

* Medicare

  -- New outpatient prescription drug benefit -- identical to standard benefit package with $250 Rx deductible and 20% cost-sharing

    - Cost: $72 b over 1996-2000

- Except for a separate deductible, drugs would be "regular" Part B benefit and would be financed through combination of premium and general revenues with the premium accounting for 25% of costs

-- The Secretary of HHS would have the authority to permit States to integrate Medicare beneficiaries into the health alliances if specific conditions are met

  - Beneficiaries have the same or better coverage as under Medicare

  - Federal financial liability for Medicare beneficiaries is not increased

  - Medicare would contribute fixed contribution to Alliance

-- When individual turns 65, they could elect to stay in private plan and Medicare would make a fixed contribution to the Alliance

* Medicaid

-- Low-income, AFDC, pregnant women and children and SSI recipient would all be enrolled in health plans for their acute care benefits

-- Public payments would be based on capitation amounts based upon 95% of costs in year prior to implementation of Alliance system

-- All health plans would be required to accept Medicaid beneficiaries

-- Medicaid would continue to provide wrap-around coverage for benefits beyond the scope of the guaranteed benefit package for beneficiaries who are cash recipients

  - Federal contribution for such coverage could be funded through a block-grant approach

* VA

-- VA hospitals may contract to provide services with health plans; Veterans could elect to be covered under a plan in the alliance

-- "Medicare may reimburse VA health plans for services to higher income veterans also eligible for Medicare. The Secretary of VA and the Secretary of HHS will undertake negotiations to determine the application of Medicare rules and rates of reimbursement for VA services. (under review).

* Federal employees

  -- FEHBP would be fully integrated into plan for general public

  -- Employees purchase coverage through the regional alliance that serves the area in which they live

* Workers compensation and automobile liability health benefits would be provided by health plans, and would be subject to a fee schedule

* DOD

  -- "Military health plans may receive capitated payments from Medicare for services to Medicare beneficiaries enrolled in military plans (under review)."

Long Term Care: $80 b (1996-2000)

* Home and community-based care: new federally-financed state administered plan under Title XV of the Social Security Act

  -- Array of services defined by the State, including personal care services, and would cover severely disabled individuals of all ages

  -- Federal funding would be capped for each State based upon the number of eligible patients and per capita spending

  -- Funding levels would be increased annually according to the consumer price index plus a fixed amount

* Changes in Medicaid

  -- All States would establish "medically needy" eligibility criteria

  -- Residents would be permitted to retain $12,000 (up from $2,000) and up to $100 per month in income

* Long-term care insurance

  -- Preferred tax treatment now accorded to health insurance medical spending would be allowed for long-term care insurance premiums and expenses

  -- The Secretary would promulgate standards for regulating the content and sale of long-term care insurance policies, including mandatory inflation protection and non-forfeiture benefits

* Tax credits would be provided to working age persons with disabilities for work related personal assistance services

Administrative Simplification

* Administrative burden would be reduced by establishing uniform claims, standard rules for reimbursement, transmission standards and electronic data interchange

* Coordination of benefits would be streamlined

* States would establish plans to coordinate licensing and certification visits

* Unique provider numbers, patient numbers and coding would be established

* Standards for maintaining privacy of information would be established

Protecting Underserved Populations

* Federal government would support health services for high-risk populations, and would invest in underserved rural and urban areas

* Federal support for transportation and translation services

Malpractice

* Plans must establish alternative dispute resolution systems

* Limits on contingency fees and on non-economic damages is under consideration

* States would have option to pursue demonstrations of enterprise liability

Fraud and Abuse

* Federal criminal penalties would be established for health care fraud

* Civil monetary penalties would be established for certain activities, including filing false claims, routinely waiving coinsurance, unbundling, providing false information, and other prohibited activities

* Anti-kickback and self-referral provisions would be extended to all-payers with certain "safe harbor" exceptions

Bankruptcy and Anti-Trust

* Anti-trust exemption would be extended to health insurers through amendments to McCarren-Fergusson

* Physicians who hold equity stake in non-FFS plan can negotiate to set prices collectively

* Institutional providers can share services if State actively supervises their activities under a State policy intended to replace competition with regulation

Health Care Workforce Development

* Residency slots would be limited to 110% of the number of graduates of U.S. schools of medicine and osteopathy

* Slots would be limited to assure that half would be in primary care

* A new process (public/private) would be established to distribute slots among regions based on population

* Funding for graduate medical education would be extended to include non-hospital sites

* The National Health Service Corps and loan program would be expanded

* State "scope of practice" laws would be prohibited, except as relating to skill and training levels

* Federal support for training of non-physicians would be expanded

Public Health and Prevention

* States would be required to maintain current effort in regard to basic public health activities, including disease promotion and prevention, reporting, etc.

* Federal block grants would be established for core public health activities

* Grants would be provided to States relating to the achievement of the Healthy People 2000 objectives. The grants would be allocated by formula

Academic Health Centers and Medical Research

* Unique costs of health centers would be spread across all plans

* The National Institutes of Health would support prevention research, quality research and other research focus in priority areas

* The Secretary of HHS would identify diseases and treatments for which health plans must contract with academic health centers

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NATIONAL HEALTH EXPENDITURES

(billions of dollars)

Calendar Years	1994	1995	1996	1997	1998	1999	2000
CBO Baseline	998	1,089	1,185	1,288	1,395	1,510	1,631
% GDP	15.1	15.7	16.3	16.9	17.5	18.2	18.9
% change	9.4	9.1	8.8	8.6	8.4	8.2	8.0
Reform	999	1,112	1,237	1,314	1,376	1,438	1,495
% GDP	15.1	16.0	17.0	17.2	17.3	17.4	17.3
% change	9.4	11.3	11.2	6.2	4.7	4.5	4.0
Change in Spending:							
New Alliance	0	19	71	83	86	90	93
Other New Spending	1	4	13	20	25	33	38
Savings	0	0	-32	-77	-130	-195	-267

* Estimates are preliminary.

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BUDGETARY EFFECTS OF HEALTH REFORM

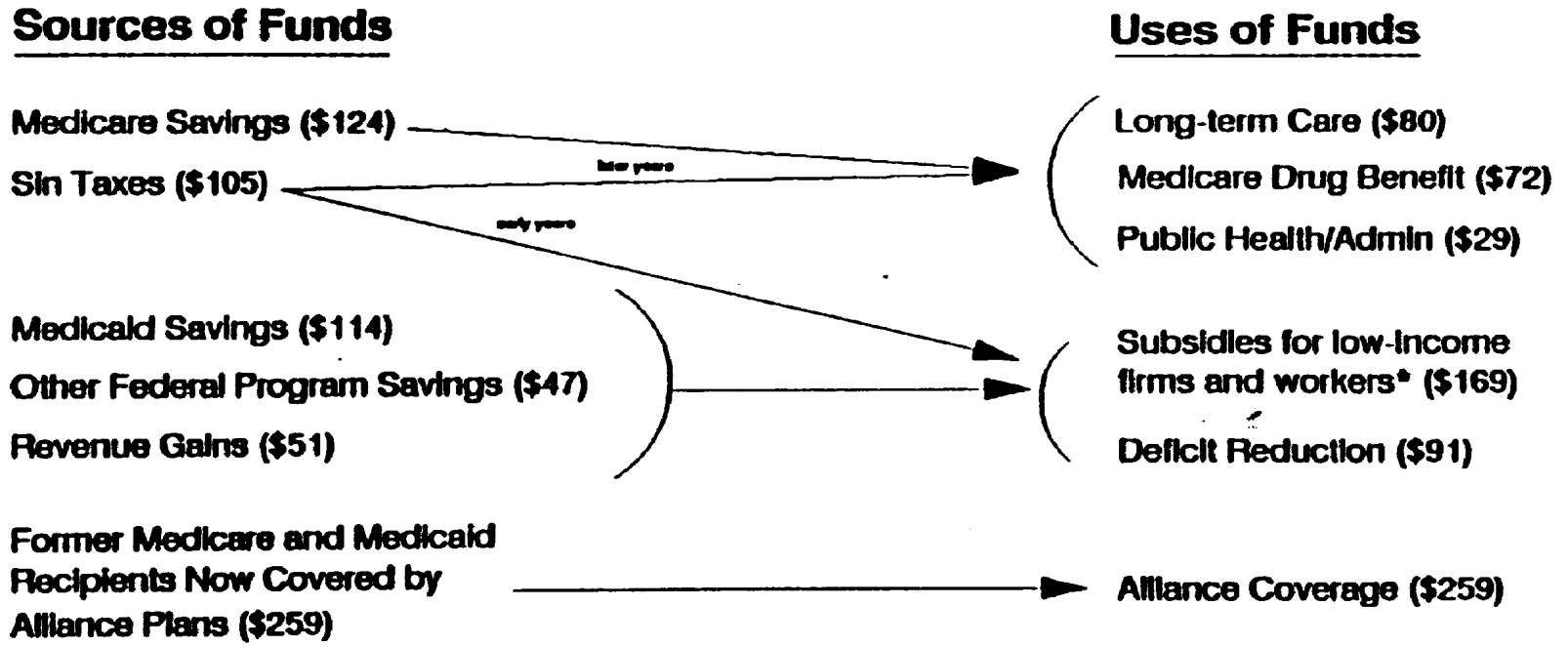
(billions of dollars)

Fiscal Years	1994	1995	1996	1997	1998	1999	2000	1994-98	1996-00
Changes in Outlays for Existing Programs	0	-5	-28	-53	-73	-94	-123	-159	-371
Medicaid	0	-4	-21	-36	-46	-57	-70	-107	-230
Liberalized Long-term Care Eligibility	0	0	1	1	1	1	1	3	5
Offset for Medicaid-eligibles in Alliances	0	-4	-15	-22	-25	-28	-31	-66	-121
Savings Due to Cap	0	0	-7	-15	-22	-30	-40	-44	-114
Medicare	0	-2	-5	-12	-20	-30	-44	-39	-111
Cost of Drug Benefit (with Rebate)	0	0	10	14	15	16	17	39	72
Offset for Employed Beneficiaries	0	-2	-8	-11	-12	-13	-15	-33	-59
Savings Due to Cap	0	0	-7	-15	-23	-33	-46	-45	-124
Veterans	0	0	-1	-2	-2	-2	-2	-5	-9
Defense Department Health	0	0	0	0	0	0	-1	0	-1
Federal Employees Health Benefits	0	0	-2	-4	-5	-6	-7	-11	-24
New Public Health Initiatives	0	1	3	3	3	4	4	10	17
Public Health Savings	0	0	-2	-2	-3	-3	-3	-7	-13
Added Outlays for New Programs	1	12	52	76	86	95	103	227	412
Long-Term Care (Net of Premium)	0	0	3	8	13	19	25	24	68
Subsidies (a)	0	14	58	80	86	89	92	238	405
less State Offset for Medicaid in Alliance	0	-3	-10	-14	-15	-15	-16	-42	-70
New Administrative Costs	0	0	1	2	2	2	2	5	9
Start Up Costs	1	1	0	0	0	0	0	2	0
Total Outlay Changes	1	7	24	23	13	1	-20	68	41
Receipts Changes	12	15	15	18	23	26	31	83	113
Sin Taxes/Corporate Assessment	12	15	15	15	16	16	16	73	78
Tax Incentives for Long-term Care	0	0	-1	-1	-1	-2	-2	-3	-7
Expanded Deduction for Self-Employed	0	0	-1	-2	-2	-2	-2	-5	-9
Effects on Other Taxes of the Mandate (b)	0	0	2	6	10	14	19	18	51
Deficit	-11	-8	9	5	-10	-25	-51	-15	-72

(a) From Urban Institute using HCFA premiums.
(b) Unofficial estimate.
* Estimates are preliminary and do not incorporate interactive effects.

How Reform Is Financed

($ billion, 1994-2000)



* Includes self-employed tax deduction.

Estimates are preliminary and do not incorporate interactive effects.