Draft Outline for Senate Finance Committee Chairman's Mark

Health Security Act of 1994

I. Insurance Reforms

A. Guaranteed Issue: Require insurers to accept all applicants.

B. Guaranteed Renewal: Prohibit insurers from terminating or failing to renew coverage.

C. Pre-Existing Conditions: Prohibit insurers and employer plans from imposing any exclusions for pre-existing conditions.

D. Modified Community Rating

1. Permit variation for family size, geography, and age (with limits so that the highest age-adjusted premium for a given family size and geographic area would be no more than twice the lowest age-adjusted premium).

2. Require all firms with fewer than 500 employees to purchase community rated insurance and prohibit self-insuring below this level.

3. Treat existing Taft-Hartley and rural cooperative plans with 500 or more employees, and bona fide multiple employer plans (MEWAs) with 1000 or more employees, as large employers; however, prohibit MEWAs from self-insuring and limit each such plan to its present size.

E. Risk adjustment and reinsurance mechanisms: The Secretary of HHS would develop mechanisms for implementation by the States.

F. Antitrust Reform: Repeal health insurance immunity from antitrust suits under the McCarran-Ferguson Act.

II. Coverage: Employer and individual mandate with special rules for small business

A. All employers with more than 20 employees would be required to pay 80 percent of the average premium for a qualified standard health plan; employees would be required to pay 20 percent, or less if the employer elects to pay more. (Non-workers and workers in exempt firms would be responsible for the full cost of the standard plan.)

B. Small employers (20 employees or fewer) would have the option to be excluded from the 80 percent mandate; firms exercising the option would pay a payroll assessment of 1 percent if they have 1-10 employees and 2 percent if they have 11-20 employees.

C. Trigger: The employer mandate would be imposed on small employers

1. at the end of 1998 if 97% of all employees (and their dependents) are not receiving employer-provided health insurance or

2. at the end of the year 2000 if 96.5% of all employees (and their dependents) are not receiving employer-provided health insurance.

III. Subsidies: Payable to both individuals and employers (including firms with 20 or fewer workers that voluntarily provide coverage)

A. Individuals: Family payments for the 20 percent share would be capped at 5 percent of income up to $30,000. Families with incomes below 150 percent of poverty would pay less, based on a sliding scale. Workers in exempt firms who are responsible for paying the full premium would be eligible for income-based subsidies that cap total payments at 5 to 7 percent of income up to $30,000.

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B. Employers: In general, employer contributions would be limited to no more than 12 percent of each worker's wage. For firms with 11-75 employees with average wages below $24,000, the cap on contributions would be as low as 5.5 percent. For low wage firms with 10 or fewer employees that elect to pay premiums, premiums would be capped at one-half the otherwise applicable rate, ranging from 2.8 to 6.0 percent of each worker's wage. Eligibility for a subsidy would be based on the individual worker's wage; however, the amount of the subsidy would be based on firm size and the average wage of the firm.

C. Independent contractor and S-corporation shareholder anti-abuse provisions would be included.

IV. Benefits

A. Mental illness services would have parity with services for other medical conditions. The Secretary of HHS would develop standards for the appropriate management of these benefits.

B. The benefit package would have an actuarial value equivalent to the Blue Cross/Blue Shield Standard Option under the FEHB program.

C. Cost-sharing options described in statute would include co-payments, co-insurance, and deductible amounts for services other than clinical preventive services.

D. Plans would be required to offer a standardized set of covered services.

E. Categories of covered services specified in statute would include: hospital services; health professional services; emergency and ambulatory medical and surgical services; clinical preventive services; mental illness and substance abuse services; family planning and services for pregnant women; hospice care; home health care; extended care; ambulance services; outpatient laboratory, radiology and diagnostic services; outpatient prescription drugs and biologicals; outpatient rehabilitation; durable medical equipment, prosthetic and orthotic devices; vision and dental care for children; and investigational treatments.

F. National Health Benefits Board

1. A National Health Benefits Board would be established in the Department of HHS to clarify covered services and cost-sharing; define medical necessity and appropriateness; consult with expert groups for appropriate schedules for covered services; refine policies regarding coverage of investigational treatments; and propose modifications to the benefits package that would go into effect unless vetoed down by Congress under fast-track procedures.

2. The Board would have 7 members nominated by the President and confirmed by the Senate. They would serve 6 year, overlapping terms.

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V. Health Insurance Purchasing Cooperatives

A. Voluntary Participation: No employer or individual would be required to purchase through a cooperative. Individuals and employers eligible to purchase insurance through a cooperative could elect to purchase insurance at modified community rates through a broker or insurance company.

B. Eligibility: Firms with fewer than 500 employees (and their employees), self-employed individuals, and individuals not connected to the workforce, as well as dependents of those persons, would be eligible to purchase insurance through a cooperative.

C. Competing Cooperatives

1. Cooperatives would be permitted to contract selectively with certified health plans. If a cooperative negotiates a price lower than the community rate, that price becomes the plan's new community rate.
2. Nothing would prevent a cooperative from serving more than one area.
3. If a cooperative were not established in every area by 1996, the State would be required to sponsor or establish a cooperative. In such cases, the State would only be required to establish or sponsor one cooperative that could serve all unserved areas within the State.

D. Federal Employees Health Benefits (FEHB) program: Employers with 2-10 employees who contributed at least 50% of the cost of health insurance would be permitted to enroll their employees in a FEHB program at the same premium price (both employer and employee share) paid by federal employees, plus an administrative fee.

E. Rules for Cooperatives

1. Cooperatives would be required to accept all eligible individuals and employers within the area.
2. Individuals not connected to the workforce would enroll based on residence.
3. Cooperatives could require payroll deductions for employed individuals.
4. If employees ask their employers to make payroll deductions for a cooperative, employers would be required to comply.

F. Choice of Health Plans/Cooperatives

1. Enrollees, not employers, would choose a health plan within the cooperative. Employees of the same employer could choose different health plans.
2. Employers above the community rating threshold would be required to provide employees with a choice of at least three health plans, including a fee-for-service plan.
3. Employees of firms with 20 or fewer employees whose employer contributes at least 50% of the cost of health insurance could enroll in a cooperative chosen by the employer. Employees could purchase insurance at modified community rates elsewhere, but the employer would not be required to make the same contribution to insurance costs.
4. Employees of firms with 20 or fewer employees whose employers do not contribute at least 50% to the cost of health insurance could enroll based on either residence or worksite.

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G. Governing Structure
   1. Cooperatives would be non-profit organizations governed by a board of directors elected by members of the cooperative.
   2. Insurers would be prohibited from forming a cooperative, but would be permitted to administer a cooperative.

H. Duties of Cooperatives
   1. Cooperatives would be required to enter into agreements with health plans, employers and individuals; collect and forward premiums to health plans; coordinate with other cooperatives; and provide a complaint process.
   2. Cooperatives would be expressly prohibited from approving or enforcing provider payment rates; performing any activity relating to premium payment rates; and bearing insurance risk.

VI. Cost Containment

A. Managed competition would help contain costs by encouraging consumers to make informed health care purchasing decisions based on the price and quality of a standardized benefit package, by banding consumers into large purchasing pools with lower administrative costs, and by encouraging providers to form more efficiently organized delivery systems.

B. Premium Targets
   1. Targets for changes in per-capita premiums would be set by law at CPI plus or minus an adjustment factor that would take into account increases in real per-capita income, changing demographics and health status indicators, and changes in medical technology and the use of services.
   2. An independent National Health Cost Commission would be established to monitor per-capita premiums. The Commission would have 7 members nominated by the President and confirmed by the Senate. They would serve 6 year, overlapping terms.
   3. If the Commission determines that the targets have been exceeded, it would recommend appropriate actions for consideration by the Congress under fast-track procedures.

C. Federal Deficit Control
   1. OMB would determine annually, through 2004, whether enactment of health care reform had caused an unprojected increase in the deficit.
   2. Any deficit increase would trigger automatic reductions in subsidies unless Congress enacts alternative budget reductions (considered by fast-track) or OMB determines that GDP growth has fallen below 0% for 2 consecutive quarters.

D. Malpractice Reforms
   1. Alternative dispute resolution (ADR) procedures would be established by health plans and malpractice claims could not be brought in court until they had gone through the plan's procedures.
   2. Contingency fees paid to attorneys would be limited to a sliding-scale schedule.
   3. Awards would be reduced by the amount of any payment for the same injury from another source.

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4. Payments of over $100,000 could be made on a periodic schedule determined by the court.
5. Demonstration projects would be authorized for limiting liability to health plans rather than physicians.
6. Demonstration projects would be authorized for adopting medical practice guidelines as the standard of care in medical liability actions.
7. Federal law would preempt inconsistent State laws except to the extent such laws imposed greater restrictions on attorney fees or a person's liability, or permitted additional defenses to malpractice actions.
8. Federal law would govern actions in State courts and would not establish a basis for bringing malpractice actions in federal courts.

B. Administrative Simplification and Paperwork Reduction
1. Establish a process for setting health information standards for paper and electronic transactions.
2. Create a public/private health information network to facilitate cost effective administration and practice of health care including automated coordination of benefits and claims routing.
3. Issue health identification cards using the Social Security number.
4. Require all health providers and plans to use standard electronic transactions to conduct business after a grace period for implementation.
5. Fund demonstration projects in telemedicine and electronic medical record systems in primary care.
6. Certify organizations to produce aggregated data for quality assessment, public health, research, and planning.

F. Fraud
1. Federal sanctions would be applied to all health care fraud that affects federal subsidies or other federal outlays.
2. A health care anti-fraud trust fund would be established to fund federal enforcement activities; a portion of the fines and civil penalties collected from such activities would go to the trust fund and the remainder to the Treasury.

VII. Financing (unofficial estimates)

A. Revenue Raisers (over 5 years)
1. Increase tobacco excise tax to $2.00 per pack = $96 billion.
2. Increase handgun ammunition excise tax to 50% (except .22 caliber) = $140 million.
3. Impose a 1% employer payroll assessment on firms of 500 or more employees = $50 billion.
4. Extend HI tax to all State and local employees = $6 billion.
5. Recapture Medicare part B subsidies for individuals with incomes over $90,000 and couples with incomes over $115,000 = $4 billion.
6. Health benefits provided through a flexible spending arrangement would not be excludable = $2 billion.

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7. Levy an assessment on health insurance premiums, phased up to 2.5% of premiums by 1999, for academic health centers and medical education and research = $40 billion.
8. Payroll assessments on small firms that do not provide coverage = $10 billion.

B. Revenue Losers (over 5 years)
1. Provide 80% self-employed health insurance deduction = (35) billion.

C. Medicare Savings (over 5 years) = $33 billion.

VIII. Medicaid

A. Mainstreaming of AFDC and Non-Cash recipients: Both groups would be treated like other low-income individuals and families for purposes of community rating, enrollment in health plans and subsidies. States would pay a maintenance of effort based on current spending on these groups for services covered in the benefit package.
B. SSI recipients: Those not enrolled in Medicare could enroll in health plans. States could make premium payments based on negotiations with certified health plans.
C. Services not covered in the standard benefit package: Retain current Medicaid mandatory and optional eligibility groups for provision of services not otherwise provided by health plans. States could negotiate with health plans to provide supplemental services.
D. Federal matching payments: Enhance matching payments for Medicaid home and community based long term care services, and change overall federal Medicaid matching formula.

IX. Long-Term Care

A. Retain Medicaid long-term care program with improvements.
B. Establish federal long-term care insurance standards.
C. Include tax credit for cost of personal assistance services for working disabled.
D. Exclude certain accelerated death benefits from taxable income.

X. Medicare

A. Maintain Medicare as a separate program.
B. Individuals could maintain coverage through private health plans when they become eligible for Medicare.
C. Medicare Select would become a permanent option in all States.
D. Medicare risk contracts would be improved.
E. Improvements in hospital payment methodologies would include:
1. Medicare Dependent Hospital Extension,
2. EACH/RPCH program improvements and extension to all States,
3. making Medical Assistance Facilities permanent and available to all States,
4. extending the rural health transition grant program, and
5. rebasing PPS exempt hospitals.

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XI. Academic Health Centers and Medical Education and Research

A. Academic Health Centers (AHCs) Trust Fund

1. A trust fund for AHCs would be established with contributions from the Medicare indirect medical education (IME) adjustment at current law levels, plus a portion of revenues from a 1.5% assessment on premiums and on premium equivalents for self-insured plans.
2. Payments would be made to all AHCs and teaching hospitals in a manner modeled after the current IME adjustment.
3. Payments would total $6.28 billion in 1996, $7.25 billion in 1997, $8.22 billion in 1998, $9.4 billion in 1999, and $10.64 billion in 2000, increased annually thereafter by the change in the national premium targets.

B. Biomedical and Behavioral Research

1. A Health Research Trust Fund would be established to fund expanded biomedical and behavioral research through NIH.
2. The trust fund would be financed with an assessment on premiums and premium equivalents equal to 0.25% in 1996, 0.50% in 1997, 0.75% in 1998, and 1.0% in 1999 and subsequent years. Also, the tax code would be amended to authorize persons filing Federal tax returns to elect to make contributions to the trust fund or to donate tax overpayments to the trust fund.

C. Graduate Medical and Nursing Education Trust Fund

1. A trust fund for graduate medical and nursing education and for transitional costs would be established with contributions from Medicare direct medical education costs at current law levels, plus a portion of revenues from the 1.5% assessment on premiums and premium equivalents.
2. Graduate medical education payments would be made to qualified applicants operating approved residency programs or participating in voluntary consortia.
   a) Payments would be based on historical costs of individual programs.
   b) Payments would total $3.2 billion in 1996, $3.55 billion in 1997, and $5.8 billion in 1998, increased annually thereafter by the change in the national premium targets.
3. Graduate Nursing Education
   a) Payments would be made to qualified applicants operating graduate nurse training programs based on national average costs with a geographic adjustment factor.
   b) Payments would total $200 million in 1996, increased annually by the change in the national premium targets.
4. Medical School Account
   a) Payments would be made to medical schools to assist in meeting additional teaching and research costs associated with the transition to managed competition and expanded ambulatory teaching.
   b) Payments would total $200 million in 1996, $300 million in 1997, $400 million in 1998, $500 million in 1999, and $600 million in 2000, increased annually thereafter by the change in the national premium targets.

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XII. Access Issues in Urban and Rural Areas

A. A trust fund based on a portion of receipts from the tobacco tax (approximately $1.3 billion per year) would be established for infrastructure development. It would provide funding for the development of health plans and capital investment for hospitals and other facilities.

B. Provide tax incentives for practitioners that locate in designated urban and rural areas.

XIII. State Flexibility

A. States would have the option to establish a single-payer system.

B. States would have the option to implement other systems designed to increase coverage, control costs, or fund uncompensated care, but which do not have a significant adverse impact on the administration of plans maintained by multi-State employers.

XIV. Privacy and Confidentiality

A. Protect all health information which could be related to a specific individual, regardless of form or medium.

B. Specify appropriate and necessary uses and reasons for release of protected information.

C. Reduce the amount of information released to the minimum necessary to perform authorized tasks.

D. Other uses and release of protected information, without specific authorization by the individual concerned, would be subject to penalties.

E. Define individual rights to access, annotate, and limit release of protected information.

XV. Health Plan Standards

A. National standards for health plans would be set by the Secretary of HHS for:

1. Capital and solvency standards, including guaranty fund, capital requirements, and risk adjustment/reinsurance;
2. Quality standards for quality improvement and assurance, continuity of care, physician credentialing, utilization management, and medical recordkeeping;
3. Patient protection standards for advance directives, physician incentive plans, participation by physicians in policymaking, anti-discrimination, grievance procedure, confidentiality, marketing, and ethical business conduct; and
4. Access standards for specialized services and essential community providers.

B. Accreditation and Enforcement

1. States would certify that health plans meet the national standards using a State program or private accreditation organization.
2. Federal grants would be available to States to help fund their enforcement programs.

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XVI. Quality and Consumer Information

A. Provide Federal funding to support research on appropriateness and outcomes of medical treatments.
B. The Secretary of HHS would provide grants to quality improvement foundations to disseminate research findings to improve provider practice patterns.
C. States would be required to provide health care consumers with comparative value information on health plans. Federal grants would be available to States to help fund their programs.
D. States would be required to establish a standardized appeals process for benefit denial, reduction or termination.
E. Modify Federal remedies for benefit denials, reductions or terminations.

XVII. Tax Treatment of Health Care Organizations

A. Strengthen current law "community benefit" standard for tax exemption for non-profit hospitals.
B. Repeal cap on tax-exempt bonds for section 501(c)(3) organizations.
C. Repeal special deduction for Blue Cross/Blue Shield organizations.
D. Limit tax exemption for HMOs to "staff" or "dedicated group" model.
E. Impose certain penalty excise taxes ("intermediate sanctions") on tax-exempt health care organizations for transactions involving private inurement.

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