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FINANCE COMMITTEE

THE WHITE HOUSE

WASHINGTON

MEMORANDUM

To: Hillary Rodham Clinton

From: Chris Jennings

Date: June 28, 1994

Re: Senate Finance Committee Update

cc: Melanne Verveer

Attached is the Chairman's mark that Senator Moynihan released earlier this evening. This is the proposal that incorporates the same trigger to an employer/employee requirement that Senator Breaux advocated several weeks ago.

Also attached is the latest version of the "rump group" proposal. Earlier today we met with Christy Ferguson of Senator Chafee's staff and Susan Foote of Senator Durenberger's staff to discuss their latest proposal. Interestingly, Mike Dahl of Senator Bradley's office also was an unexpected participant. During the conversation it became clear that they are considering other modifications to their proposal that would provide for more certain budget neutrality guarantees. It is also clear based on other conversations that they and Senator Danforth's staff remain open to a hard trigger to an individual mandate, yet prefer to hold off any such change until the full Senate considers floor amendments.

The Finance Committee will be meeting tomorrow to walk through the Chairman's mark and receive opening statements. Senator Moynihan and Senator Packwood have agreed to a 36-hour review period of the Chairman's mark. This means that votes on and amendments to the Chairman's mark will not take place until Thursday. At that time, it appears that Senator Moynihan will try to push for a vote on his mark; it remains very unclear however as to whether the other members will be prepared to vote on Senator Moynihan's proposal.

As of this writing, it appears certain that Senators Boren, Breaux and Conrad will vote against the hard trigger proposal. Should this occur, we have eight remaining Democrats who potentially might vote for it and would provide a strong base for an employer requirement. Having said that, Senators Bradley and Baucus are likely to be very difficult votes to attract to this package. I am working with Pat, Harold and Steve to develop a strategy to create an environment in which they would be more likely to vote for this package. (For example, we may need to work with Senator Baucus in helping him draft an amendment to provide greater assistance to small businesses; with Senator Bradley, we will continue our outreach effort with old influential staff such as Susan Thomases and Ken Apfel as well as an ongoing outreach effort from Harold). We will keep you apprised of any developments.

We are united in our belief that our highest priority is getting a bill, preferably a reasonably solid bill, out of the Finance Committee as soon as possible. However, keeping in mind that the committee will insist upon at least some CBO numbers to back up their proposals, and considering how few days remain before the July 4th recess, it appears highly unlikely that the committee will report out a bill prior to the members departure for their break. The best we can hope for is getting some type of agreement on the basic foundation of a compromise that can achieve committee support (which can be scored by CBO/OMB over the recess).

To help facilitate timely action by the committee, we have been providing significant technical assistance to the Chairman's staff. Much of this assistance is represented in the Chairman's mark. At the lower staff level, they are very appreciative of our assistance. We will need to continue to build on this relationship in order for the committee to develop a package that can be scored as a budget neutral or deficit reducing initiative. For example, it will be very difficult to make the numbers work for a policy marriage between the Chairman's mark and the Chafee "rump group" proposal. (This is important because the committee now believes that this is the direction they will go). We will continue to encourage the committee staff to call on us for assistance.

DRAFT

June 28, 1994
4:28 P.M.

COMMITTEE ON FINANCE

CHAIRMAN'S MARK

HEALTH SECURITY ACT OF 1994

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HEALTH SECURITY ACT OF 1994

I. INSURANCE REFORM STANDARDS

A. REQUIREMENTS FOR INSURED HEALTH PLANS

Present Law

Federal law generally does not govern the sale of insured health plans to individuals or groups. The two exceptions are Title XVIII of the Social Security Act that regulates the sale of supplemental Medicare policies (Medigap policies) and Title XIII of the Public Health Service Act which sets out standards (including benefit package and rating) for health maintenance organizations that choose to be federally qualified. States set standards for insurance policies and many States have enacted insurance reforms in the past three years.

Description of Proposal

1. State Responsibilities

Participating States would be required to certify that primary insurance coverage offered for sale by commercial insurance companies, Blue Cross plans, integrated health plans, and other organizations that assume health insurance risks ("insured health plans") comply with new Federal standards. Federal Medicaid matching payments would not be available to non-participating States. Federal low-income premium subsidies could only be paid for individuals enrolled in State-certified standard insured health plans.

Insured health plans not meeting standards for certification would be subject to a civil monetary penalty not to exceed 50 percent of gross premiums during the period in which the violations occurred.

2. Guaranteed Issue

Insured health plans would be required to accept all individuals and their dependents, and all groups that apply for coverage. Insured health plans could not deny coverage based on health status, medical condition, claims experience, receipt of health care, medical history, anticipated need for health care services, disability, or lack of evidence of insurability.

Insured health plans would be required to issue coverage to individuals or groups except when (i) the health plan demonstrates that such enrollment would cause it to exceed service capacity or (ii) the individual or group has not requested enrollment during the open enrollment period. Each health plan would be required to have at least one annual

open enrollment period of 30 days. Enrollment in a health plan outside the open enrollment period would be permitted without penalty under a limited set of circumstances including marriage, court order, and change in employment status.

Subject to Part V, insured health plans would be required to offer coverage through all purchasing cooperatives in a community rating area, and would be required to sell outside the cooperatives.

An exception to the guaranteed issue rule would be made for religious fraternal benefit societies that were in existence as of September 1993, which bore the risk of providing insurance to their members, and which receive tax-exempt status under Sec. 501(c)(8) of the Internal Revenue Code.

Effective Date

January 1, 1996.

3. Extended Coverage of Dependents

Insured health plans would be required to offer family coverage that includes coverage of dependent unmarried children up to age 24 and spouses.

Effective Date

For policies issued or renewed on or after January 1, 1996.

4. Guaranteed Renewal

Insured health plans would be prohibited from terminating or otherwise failing to renew coverage for groups or individuals except in the case of 1) nonpayment of premiums; 2) fraud on the part of the policyholder or purchaser; or 3) misrepresentation by the policyholder or purchaser on an application for coverage or claim for benefits.

Effective Date

For policies in effect on or after June 28, 1994.

5. Limits on Pre-Existing Condition Exclusions (Portability)

a. Insured health plans could not exclude coverage of treatment for a pre-existing condition for more than 6 months from date of plan enrollment. A condition is pre-existing if it was treated or diagnosed in the 6 months prior to the date of enrollment. Insured health plans could not apply exclusions if individuals were recently insured by another health plan. Insured health plans could not apply pre-existing condition limitations to newborn coverage and would be required to offer automatic coverage of newborns on the parent's policy.

Effective Date

For policies issued on or after January 1, 1996.

b. Insured health plans could exclude from coverage only a condition that was treated or diagnosed in the 3 months prior to enrollment. Insured health plans could not limit coverage when the pre-existing condition is pregnancy.

Effective Date

For policies issued on or after January 1, 1997.

6. One-Time Amnesty for Pre-Existing Conditions

Insured health plans would be required to enroll, without pre-existing condition limitations, any uninsured person who applies for enrollment. This one-time amnesty would be effective only during the first open enrollment period after the effective date of this section.

Effective Date

For the first open enrollment period beginning on or after January 1, 1996.

7. Standardized Benefit Package

Insured health plans would be required to offer a standardized benefit package as a separate package, in conformance with other requirements of the legislation.

Effective Date

For policies issued or renewed on or after January 1, 1996.

8. Modified Community Rating

a. States would be directed to establish geographic areas ("community rating areas") within which insured health plans would be required to community rate. Each State would determine the number of such areas within it. However, a community rating area could not subdivide a Metropolitan Statistical Area (MSA) and must contain at least 250,000 individuals. In establishing a community rating area, States could not discriminate on the basis of health status or the perceived need for health services. MSAs that cross State boundaries could be treated as one community rating area if both States agree to cooperate.

b. The community-rated market would include all eligible individuals who are not (i) employees (and their dependents) of an employer with 500 or more employees (other than an employer whose primary business is employee leasing); or (ii) participants in a Taft-Hartley plan, rural cooperative plan, or multiple employer welfare arrangement (MEWA) grandfathered under

section C.2 of this Part.

c. Insured health plans selling policies in the community-rated market would be permitted to offer only policies that are community rated, modified for the location of the community rating area, family size, and age. The age adjustment would be limited so that the ratio between the highest and the lowest rate within a family class in a given geographic area could not exceed 2:1 for the population under age 65. The Secretary of HHS would consult with the National Association of Insurance Commissioners to develop uniform age categories and rating increments within 6 months of enactment.

d. Employer discounts for certain workplace wellness activities would be permitted.

Effective Date

For policies issued or renewed on or after January 1, 1996.

9. Risk Adjustment

a. The Secretary of HHS would be required to develop a risk adjustment mechanism that States would implement. All insured health plans in the community-rated market (inside and outside the purchasing cooperatives) would be required to participate. The risk adjustment mechanism would account for differences in the demographics, health status, and poverty and subsidy status of plan enrollees.

b. The Secretary of HHS would be required to develop, and States would be required to implement, a separate adjustment mechanism to redistribute losses among insured health plans resulting from the reduced cost sharing obligations of persons receiving subsidies, which must be absorbed by individual insured health plans as described in Part III (Subsidies).

c. States would also be required to operate reinsurance pools which meet Federal requirements until a risk adjustment mechanism is developed and implemented.

d. Nothing would prevent a reinsurance system and risk adjustment system from operating concurrently if the Secretary determines this is desirable.

Effective Date

States would be required to establish reinsurance pools by January 1, 1996, and implement a risk adjustment mechanism by January 1, 1997. States would be required to implement a cost-sharing subsidy redistribution system by January 1, 1997.

10. Exit from the Market

During the transition to community rating, insured health plans could terminate coverage of individuals or employers with fewer than 100 employees only if they terminate coverage for all such individuals or groups in the State (or terminate coverage in both these markets if the health plan operates in both markets) and would then be prohibited from re-entering the market(s) in the State for five years.

Effective Date

Effective upon enactment until January 1, 1996.

B. REQUIREMENTS FOR SELF-INSURED HEALTH PLANS

Present Law

The Federal government regulates employment-based health plans under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA requires reporting and disclosure of certain information to the Department of Labor (DOL) and imposes fiduciary responsibilities on plan sponsors.

Description of Proposal

1. Federal and State Responsibilities

a. Participating States would be required to certify self-insured plans that operate in only one State. The Secretary of Labor would be required to certify multistate self-insured plans.

b. Self-insured plans that are not certified as satisfying the following requirements would be subject to a civil monetary penalty not to exceed 50 percent of gross health plan expenditures during the period in which the violations occurred.

2. Guaranteed Issue

Self-insured health plans could not deny coverage or vary premiums based on health status, medical condition, claims experience, receipt of health care, medical history, anticipated need for health services, disability, or lack of evidence of insurability.

Effective Date

January 1, 1995.

3. Guaranteed Renewal

Self-insured plans could not terminate or otherwise fail to renew an individual's coverage due to the individual's health status, medical condition, claims experience, receipt of health care, medical history, or

lack of evidence of insurability.

Effective Date

June 28, 1994.

4. Extended Coverage of Dependents

Self-insured health plans would be required to offer family coverage that includes coverage of dependent unmarried children up to age 24 and spouses.

Effective Date

January 1, 1996.

5. Limits on Benefit Reductions

Self-insured plans could not reduce or limit coverage for any condition or course of treatment for which the anticipated cost for an individual is likely to exceed $5000 in any 12-month period. Any such modification would not be effective and the self-insured sponsor would be required to provide benefits as though the modification had not occurred.

Effective Date

June 28, 1994 until January 1, 1996.

6. Limits on Pre-Existing Condition Exclusions (Portability)

a. Self-insured plans could not exclude from coverage, for more than 6 months from the date of plan enrollment, treatment of a pre-existing condition. A condition is pre-existing if it was treated or diagnosed in the 6 months prior to the date of enrollment. Self-insured plans could not apply exclusions if individuals were recently insured by another health plan, nor could plans apply pre-existing condition limitations to newborn coverage. Plans would be required to offer automatic coverage of newborns on a parent's policy.

Effective Date

January 1, 1996.

b. Self-insured plans could only exclude from coverage a condition that was treated or diagnosed in the 3 months prior to enrollment. Plans could not limit coverage when the pre-existing condition is pregnancy.

Effective Date

January 1, 1997.

7. One-Time Amnesty for Pre-Existing Conditions

Self-insured plans would be required to enroll, without pre-existing condition limitations, any group member who is otherwise eligible for coverage. This one-time amnesty would be effective only during the first open enrollment period under reform.

Effective Date

The first open enrollment period beginning on or after January 1, 1996.

8. Standardized Benefit Package

Self-insured plans must provide a standardized benefit package as a separate package, in conformance with other requirements of the legislation. Plans could provide additional benefits through certified supplemental policies.

Effective Date

Effective for new coverage or renewals beginning on or after January 1, 1996.

C. REQUIREMENTS FOR EMPLOYERS

Present Law

No provision.

Description of Proposal

1. Employer Responsibility to Make Insurance Available

a. Employers in the community-rated market

Any employer in the community-rated market would be required to make payroll deductions for health insurance for each employee that requests it. These employers would be required to make available at least three certified standard health plans in the community-rated pool, including a fee-for-service option and a point of service option. An employer in this market would be permitted to meet this requirement by offering coverage through a purchasing cooperative that offers at least three types of certified standard health plans at the community rate.

b. Other employers

Employers not in the community-rated market would be required to make payroll deductions for employees who request it. These employers would be required to make available at least three types of certified standard health plans, including a fee-for-service plan and a point of service

option. These employers would not be permitted to purchase health plan coverage in the community-rated market.

c. Enforcement

A civil monetary penalty would be assessed on employers for failure to comply with any of the preceding requirements. The penalty would not exceed 25 percent of the wages of affected employees during the period in which the violation occurred.

Effective Date

January 1, 1996.

2. Employers that are Permitted to Self-Insure

Only employers and organizations described in one of the following categories would be permitted to sponsor a self-insured or experience-rated health plan:

(a) Employers (other than employers whose primary business is employee leasing) with 500 or more employees;

(b) Grandfathered Taft-Hartley or rural cooperative plans; and

(c) Grandfathered multiple employer welfare arrangements (MEWAs).

Existing Taft-Hartley and rural electric and telephone cooperative health plans with at least 500 participants would be permitted to self-insure or purchase experience-rated insurance. MEWAs in existence as of January 1, 1991 that are maintained by a bona fide group or association of employers or by an employee organization and that covered at least 1000 participants as of June 1, 1994 also would be permitted to continue to provide health care coverage. However, grandfathered MEWAs (1) could not self-insure, (2) could not increase the number of participants covered under the arrangement by more than 5 percent, and (3) would be subject to new, more stringent, Federal standards. (Two or more employers with 500 or more employees who form a MEWA would not be subject to these MEWA rules.)

Effective Date

January 1, 1996.

D. ANTITRUST REFORM

Present Law

The McCarran-Ferguson Act (15 U.S.C. §§1011-15) provides that the "business of insurance" is exempt from Federal antitrust laws, provided that such business is regulated by the State and that the challenged

actions do not constitute a boycott or coercion or intimidation.

Description of Proposal

Immunity from antitrust suits under the McCarran-Ferguson Act with respect to health insurance would be repealed. This would not alter immunity with respect to other forms of insurance.

Effective Date

Effective for causes of action arising on or after January 1, 1996.

II. COVERAGE

Present Law

No provision.

Description of Proposal

A. COVERAGE GOAL

Universal health care coverage is the national goal of this legislation. An individual is "covered" if insured by a certified standard or very high deductible health plan, or by one of the following public plans: Medicare, Medicaid, a Department of Defense health program, a Department of Veterans Affairs health program or an Indian Health Service program.

B. NATIONAL HEALTH CARE COMMISSION

An independent National Health Care Commission would be established to monitor and respond to: (1) trends in health insurance coverage; and (2) changes in per-capita premiums and other indicators of health care inflation.

The Commission would be composed of 7 members nominated by the President and confirmed by the Senate. Commissioners would serve 6-year, staggered terms. No more than four members of the Commission may be from the same political party.

C. DETERMINATION BY COMMISSION

If the Commission determines that specified coverage goals (described in paragraph D) have not been achieved an employer mandate would automatically be triggered requiring employers to contribute 80 percent of the cost of a certified standard health plan.

D. EMPLOYERS SUBJECT TO HARD TRIGGER

FIRMS WITH 100 OR MORE EMPLOYEES: three years after enactment, if market reforms in a voluntary system do not result in 85 percent of the currently uninsured employees of firms in this category gaining coverage, a mandate would go into effect.

Percent of employees in this category who are currently uninsured.....11 percent
Number of uninsured employees in the category .....7.4 million

(85 percent of 7.4 million = 6.3 million)

Percent of all firms.....1.6
Percent of all employees.....60.8

FIRMS WITH 25 TO 99 EMPLOYEES: four years after enactment, if market reforms in a voluntary system do not result in 80 percent of the currently uninsured employees of firms in this category gaining coverage, a mandate would go into effect.

Percent of employees in this category who are currently uninsured.....21 percent
Number of uninsured employees in this category.....3.3 million

(80 percent of 3.3 million = 2.6 million)

Percent of all firms.....6.5
Percent of all employees.....15.9

FIRMS WITH FEWER THAN 25 EMPLOYEES: five years after enactment, if market reforms in a voluntary system do not result in 75 percent of the currently uninsured employees of firms in this category gaining coverage, a mandate would go into effect.

Percent of employees in this category who are currently uninsured.....26 percent
Number of uninsured employees in this category.....9.8 million

(75 percent of 9.8 million = 7.4 million)

Percent of all firms.....91.9
Percent of all employees.....23.0

E. ONGOING MONITORING

The Commission will provide on-going review of coverage rates. If at anytime after the initial determination of whether coverage goals were met for the group of firms described in paragraph C, the Commission determines that coverage has fallen below the specified goals, then the mandate for that group of firms would automatically be triggered.

F. INSURANCE ADJUSTMENTS

If a mandate goes into effect for all firms, insurance reform standards would be adjusted as follows:

1. Guaranteed Issue: Health plans would be required to provide unrestricted open health plan enrollment.

2. Pre-Existing Condition Limitations: Health plans would be prohibited from applying any pre-existing condition limitations.

G. ENFORCEMENT PENALTIES

Any employer that fails to comply with the mandate would be subject to an excise tax equal to $100 for each day for each employee for whom the employer has failed to provide coverage.

Effective Date

Upon enactment.

III. SUBSIDIES

A. PREMIUM SUBSIDIES

Present Law

No provision.

Description of Proposal

1. Eligibility

Subsidies are payable according to the following criteria:

(a) full subsidy for individuals and families with income that does not exceed 100 percent of poverty; beginning in 1997, the subsidy is phased out for those with income between 100 percent and the following percentages of poverty:

Calendar Year	Percentage of Poverty
1997	125
1998	150
1999	175
2000	200

(b) the benefit package to be subsidized is limited to the value of a certified standard health plan;

(c) no subsidy is payable for those entitled to a subsidy of $150 or less; and

(d) there is no poverty adjustment for family size above a family size of 4.

Resident citizens and aliens permanently residing in the U. S. under color of law are eligible for a subsidy for the purchase of a certified standard health plan. Undocumented aliens are not eligible.

The poverty level that will be used in determining eligibility is the official poverty line as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981.

2. Subsidy value

The full subsidy will equal the cost of the premium for a certified standard health plan, but no higher than the average cost of such a plan in the community rating area minus the amount of any contribution offered by an employer.

3. Definition of income

Income is defined as adjusted gross income (as determined for purposes of paying Federal income taxes), modified to include nontaxable interest income, the portion of social security benefits that are not subject to taxation, and welfare payments.

4. Subsidies for AFDC recipients

Recipients of AFDC who are integrated into the reformed health care system are eligible for subsidies on the same basis as all other eligible individuals. Individuals may file an application for a premium subsidy at the same time that they apply for AFDC.

5. Eligibility determination

The Secretary of Health and Human Services is directed to promulgate regulations specifying procedural requirements that States must follow in determining eligibility for subsidies, which shall include regulations relating to procedures for filing of applications, verification of information, timeliness of decision-making, appeals of adverse decisions, and such other matters as the Secretary determines to be necessary. Outreach activities by Federal and State governments will be required.

Eligibility will be calculated on an annual basis. An individual or family that has an approved application for a subsidy must file an end-of-year income reconciliation statement at such time as is specified in regulations. Failure to file a reconciliation statement will result in ineligibility for subsidies until the statement is filed, unless there is good cause.

The Secretary of the Treasury in consultation with the Secretary of Health and Human Services shall promulgate regulations providing for the use of income tax return information in determining and verifying eligibility to the extent practicable.

The agency administering the subsidy program shall pay the subsidy to which an individual or family is entitled directly to the plan in which the individual or family is enrolled. An employer of an employee whose application for a subsidy has been approved must, upon request of the employee, adjust any premium amount being withheld on behalf of the employee to reflect the premium subsidy for which the employee is eligible.

An individual who knowingly understates income in an application for a subsidy shall be liable for any excess payments made based on the understatement and for interest. An individual who knowingly misrepresents material information shall be liable for $2,000 or, if greater, three times the excess payments made based on the misrepresentation.

6. Responsibility for administration

The State shall be responsible for administration, and may designate

the public agency that it deems appropriate to carry out necessary functions. The Secretary of Health and Human Services must develop standards to assure consistency among States with respect to data processing systems, application forms, and such other administrative activities as the Secretary determines necessary to promote the efficient administration of the subsidy program. A State shall be liable to the Federal government for payments made in error.

Funds required to pay the subsidies will be transferred to the State at such time and in such form as provided in regulations. The Secretary of Health and Human Services shall provide for regular audits. A State shall be liable for payments made in error.

The Federal government will match State administrative costs at a rate of 75 percent Federal, 25 percent State.

Effective Date

States have the option of providing subsidies to those who are eligible beginning with the month of January 1996, and must provide subsidies for months after December 1996.

B. COST-SHARING SUBSIDIES

Present Law

No provision.

Description of Proposal

1. Cost-sharing for those up to poverty

Individuals and families eligible for a full subsidy (up to 100 percent of poverty) are eligible for reduced cost-sharing at point of service, as determined by the National Health Benefits Board. The plan will absorb any short-fall.

Effective Date

Upon implementation of the State subsidy program.

2. Cost-sharing for those above poverty

States will have the option of providing subsidies for cost-sharing for individuals and families with income between 100 percent and 200 percent of poverty. The State would be required to pay 50 percent of the cost, and would be responsible for establishing eligibility requirements and for administration. Capped entitlement funds will be allocated to the States on the basis of State population, beginning in fiscal year 1997. Two billion dollars a year will be available for this purpose.

C. SUBSIDIES FOR EMPLOYERS

Present Law

No provision.

Description of Proposal

1. Eligibility

a. Employers will be eligible to receive subsidies if an employer mandate is triggered (as described under Part II).

b. Employers who are subject to the mandate are required to pay 80 percent of the cost of a certified standard health plan. In general, however, employer contributions for the 80 percent share of the premium are limited to no more than 12 percent of each employee's wage.

c. Subsidies are targeted to low-wage employees irrespective of where they are employed.

d. Although eligibility for the subsidy is based on the individual employee's wage irrespective of the average wage or firm size, the amount of the subsidy is based on firm size and the average wage of the firm. Contributions are limited to 5.5 - 12.0 percent of the wage of each employee within the firm in accordance with the following schedule:

	Average Wage in Firm					
Firm Size	<12K	12-15K	15-18K	18-21K	21-24K	24K+
<26	5.5%	6.8%	8.1%	9.4%	10.7%	12.0%
26-50	6.8%	8.1%	9.4%	10.7%	12.0%	12.0%
51-75	8.1%	9.4%	10.7%	12.0%	12.0%	12.0%

e. If an employer mandate is triggered it will be implemented in accordance with a schedule described in Part II. Under this schedule, firms with fewer than 100 full-time equivalent employees are not immediately subject to the mandate. However, such firms would be eligible for subsidies, in accordance with the subsidy structure outlined in d. above, provided the firm contributed at least 50 percent to the cost of a certified standard health plan. When the mandate is phased in for these firms the subsidy would continue based on the 80 percent contribution required under the mandate.

2. Definition of Wages

Wages are defined as in the Internal Revenue Code for the purpose of determining contributions for the Hospital Insurance Trust Fund. Wages will be defined equivalently for State and local governments that do not contribute to Social Security. In the case of a partner in a partnership, a 2-percent shareholder in an S corporation, or a sole proprietor, the individual's net earnings from self-employment are deemed to be wages.

Effective Date

This provision would be effective if an employer mandate is triggered under the provisions of Part II, on or after January 1, 2002.

D. TRUST FUND FINANCING

There is created in the Treasury a Health Security Trust Fund ("Trust Fund"). All subsidies required by this Act shall be paid from funds available in the Trust Fund, as would payments for infrastructure development for designated urban and rural areas (Part XII), and quality improvements.

Revenues attributable to the increase in excise taxes on tobacco products and other revenues raised by this Act would be deposited into the Trust Fund.

Amounts equivalent to the reductions in Federal Medicaid expenditures resulting from this Act, and State Maintenance of Effort payments required under this Act, would be deposited into the Trust Fund.

If Trust Fund obligations in a year exceed Trust Fund receipts, any shortfall would be automatically deposited into the Trust Fund from general revenues.

Effective Date

Upon enactment.

IV. BENEFITS AND THE NATIONAL HEALTH BENEFITS BOARD

A. VALUE AND STRUCTURE OF THE BENEFITS PACKAGE

Present Law

No provision.

Description of Proposal

The value of the standard benefit package would be based on the actuarial value of the Blue Cross/Blue Shield Standard Option (BC/BS-SO) under the Federal Employees Health Benefits (FEHB) program, adjusted for an average population. Fee-for-service plans would have an actuarial value equivalent to the BC/BS-SO under FEHB adjusted for an average population. Integrated plans could have reduced cost-sharing, set at a level to keep average premiums at, or below, the fee-for-service levels.

Cost sharing arrangements would include co-payments, co-insurance, and deductible amounts for services other than clinical preventive services. There would be three options for certified standard health plans:

1. Higher cost sharing plan would have an annual out-of-pocket maximum of $2500 per individual or $3000 per family; $400 per individual or $800 per family deductible; 25 percent co-insurance; $250 per admission hospital deductible; $250 prescription drug deductible.

2. Lower cost sharing plan, details of which would be specified by the National Health Benefits Board.

3. Combination cost sharing plan, in which an enrollee can choose any physician, but pay higher out-of-pocket costs for physicians who are not part of the network. Cost sharing details to be specified by the National Health Benefits Board.

In addition, a certified very high deductible health plan consisting of the same covered services with a $5000 per individual or $10,000 per family deductible would be available, but not as a certified standard health plan. (Only certified standard health plans can be offered by employers.)

B. COVERED SERVICES

Present Law

No provision.

Description of Proposal

Health plans would be required to offer a standardized set of covered services. Categories of covered services would be specified in statute. A

National Health Benefits Board would be directed to refine covered services by reference to standards of medical necessity or appropriateness. Medically necessary or appropriate treatments would be defined by law as those intended to maintain or improve the biological or psychological condition of the enrollee or to prevent or mitigate an adverse health outcome to the enrollee. For individuals under 22 years of age, the Board would be directed to give consideration to age and health status to prevent or ameliorate the effects of a condition, illness, injury or disorder, to aid in the individual's overall physical and mental growth and development, or assist the individual in achieving or maintaining maximum functional capacity.

Categories of covered services and equipment would include:

1. hospital services, including inpatient, outpatient, 24-hour a day hospital emergency, and hospital services provided for the treatment of a mental or substance abuse disorder. The definition of the term "hospital" would be the same as in Medicare, with additional reference to facilities of the uniformed services, Department of Veterans Affairs and Indian Health Service.

2. health professional services, including inpatient and outpatient services and supplies (including drugs and biologicals which cannot be self-administered). Health professional services means professional services that are lawfully provided by a physician or another person who is legally authorized to provide such services in the State in which the services are provided.

3. emergency and ambulatory medical and surgical services, including 24-hour a day emergency services, or ambulatory medical or surgical services.

4. clinical preventive services, including services for high risk populations, age-appropriate immunizations, tests, or clinician visits consistent with any periodicity schedule specified by the National Health Benefits Board. The National Health Benefits Board would be directed to consult with appropriate government agencies, task forces, and professional groups (for example, using recommendations of the Advisory Committee on Immunization Practices, the US Preventive Services Task Force, and for children, the American Academy of Pediatrics).

5. mental illness and substance abuse services. The Secretary of HHS would be directed to define such services so as to achieve parity with services for other medical conditions and would develop standards for the appropriate management of these benefits. Mental disorders and substance abuse disorders would be defined, respectively, as those listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition or revised version of such manual, or the equivalent listed in the International Classification of Diseases, 9th Revision, Clinical Modification, Third Edition or a revised version of such text.

6. family planning services and services for pregnant women,

including contraceptive drugs and devices dispensed by prescription and subject to approval by the Secretary of HHS under the Federal Food, Drug, and Cosmetic Act.

7. hospice care services, as defined in Medicare.

8. home health care services, as defined in Medicare with limitations such that these services would be an alternative to inpatient treatment in a hospital, skilled nursing facility or rehabilitation facility and would be reevaluated after each 60 day period. Covered services to include treatment as a result of an illness, injury, disorder or other health condition.

9. extended care services, as defined in Medicare when provided in inpatient skilled nursing facility or a rehabilitation facility as an alternative to inpatient hospital services to include treatment as a result of an illness, injury, disorder or other health condition.

10. ambulance services provided by ground, air or water transportation using equipment for transporting injured or sick individuals, only if indicated by the medical condition of the individual or in cases in which there is no other method of transportation or where use of other methods is contra-indicated by the medical condition.

11. outpatient laboratory, radiology and diagnostic services, provided upon prescription to individuals who are not inpatients of a hospital, hospice, skilled nursing facility, or rehabilitation facility.

12. outpatient prescription drugs, home infusion drug therapy and biologicals, including accessories and supplies used directly with drugs and biologicals, including any use approved by the Food and Drug Administration or if cited in the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluations, the United States Pharmacopoeia-Drug Information and other authoritative compendia as identified by the Secretary. Blood clotting factors would be defined as in Medicare. The Secretary of HHS may revise the list of compendia.

13. outpatient rehabilitation services, including outpatient occupational therapy; outpatient physical therapy; outpatient respiratory therapy; and outpatient speech-language pathology services and audiology services as a result of an illness, injury, disorder or other health condition. The need for continued services would be reevaluated at the end of each 60 day period by the person primarily responsible for providing the services.

14. durable medical equipment (DME), prosthetics and orthotic and prosthetic devices, including accessories and supplies necessary for repair, function and maintenance of DME. DME would be defined as in Medicare; prosthetic devices are devices that replace all or part of the function of a body organ including replacement of DME and prosthetic devices; orthotic devices are those accessories and supplies used directly with prosthetic devices to achieve therapeutic benefits and proper

functioning; orthotics are leg, arm, back, and neck braces; prosthetics are artificial legs, arms, and eyes including replacements if required; and fitting and training for use of these items.

15. vision care, hearing aids and dental care for individuals under 22 years of age including eyeglasses; contact lenses; emergency dental treatment for acute infections, bleeding and injuries to prevent risks to life or significant medical complications; prevention and diagnosis of dental disease including oral dental examinations, radiographs, dental sealants, fluoride application and dental prophylaxis; treatment of dental disease including routine fillings, prosthetics for congenital defects, periodontal maintenance and endodontic services; space maintenance procedures to prevent orthodontic complications and interceptive orthodontic treatment to prevent severe malocclusion.

16. investigational treatments, including routine care provided in research trials approved by the Secretary of HHS, the Directors of the National Institutes of Health, the Commissioner of the Food and Drug Administration, the Secretary of Veterans Affairs, the Secretary of Defense, or a qualified nongovernmental research entity as defined in guidelines of the National Institutes of Health, including guidelines for National Cancer Institute-designated cancer center support grants; or a peer-reviewed and approved research program as defined by the Secretary of HHS.

Effective Date

For all policies in effect on or after January 1, 1996.

C. THE NATIONAL HEALTH BENEFITS BOARD

Present Law

No provision.

Description of Proposal

A National Health Benefits Board would be established within the Department of Health and Human Services. The Board would consist of 7 members nominated by the President and confirmed by the Senate who would serve for six-year, staggered terms. No more than four members may be from the same political party.

The Board, in consultation with expert groups, would be authorized to promulgate regulations to: clarify covered services and cost-sharing, refine the statutory definition of medical necessity or appropriateness, develop appropriate schedules for covered services, and refine policies regarding coverage of investigational treatments.

The Board would also be authorized to issue regulations to modify the categories of covered services and cost sharing that would go into effect

unless Congress overturns the regulations by joint resolution considered under fast-track procedures.

Effective Date

Board members would be named by the President within 90 days after enactment.

V. HEALTH INSURANCE PURCHASING COOPERATIVES

Present Law

No provision.

Description of Proposal

A. VOLUNTARY PARTICIPATION IN COOPERATIVES

No employer or individual would be required to purchase insurance through a health insurance purchasing cooperative. Individuals and employers eligible to purchase insurance through a cooperative could also elect to purchase insurance at modified community rates through a broker or directly from an insurance company.

B. ELIGIBILITY TO PURCHASE INSURANCE THROUGH A COOPERATIVE

All purchasers in the community-rated market would be eligible to purchase insurance through a cooperative. These include: (1) employers with fewer than 500 employees (and the individual employees of such employers); (2) self-employed individuals; (3) individuals not connected to the workforce; and (4) employers whose primary business is employee leasing. Eligible individuals could also purchase insurance on behalf of their dependents.

C. COMPETING COOPERATIVES

More than one cooperative could operate within a community rating area defined by the State under Federal standards. Cooperatives would not be required to contract with every certified health plan. If a cooperative negotiates a price lower than the community rate, that price becomes the health plan's community rate, which must be offered to all purchasers within the community rating area.

A cooperative would be permitted to serve more than one community rating area.

If a cooperative were not established in every community rating area by 1996, the State would be required to sponsor or establish a cooperative. In such cases, the State would only be required to sponsor or establish one cooperative that could serve all unserved areas within the State.

D. RULES FOR COOPERATIVES

Cooperatives would be required to accept all eligible individuals and employers in the community rating area they serve. Cooperatives would be required to ensure that their services were accessible in all parts of the community rating areas in which they operate. To ensure accessibility,

cooperatives would be authorized to make enrollment material available at designated public access sites, such as public libraries and local government offices.

Individuals not connected to the workforce would enroll in a cooperative based on residence.

Cooperatives would also be required to provide enrollees with a choice of at least three types of health plans, one of which must be a fee-for-service plan and one of which must be a plan that offers a point-of-service option. Governors could waive the requirement that cooperatives and employers offer a choice of at least three types of health plans in rural areas where the cooperative demonstrates to the Governor's satisfaction that there is insufficient population density to support three types of plans.

Cooperatives could require payroll deductions for employed individuals. Also, if employees ask their employers to make payroll deductions for a cooperative, employers would be required to comply.

Cooperatives would be prohibited from entering into contracts with health plans that are not certified.

E. CHOICE OF HEALTH PLANS AND COOPERATIVES

Enrollees, not employers, would choose a health plan within a cooperative. Employees of the same employer could choose different health plans within a cooperative.

Employers with fewer than 500 employees could choose a cooperative for their employees as an alternative to the requirement that they offer at least three types of health plans.

F. GOVERNING STRUCTURE OF COOPERATIVES

Cooperatives would be non-profit corporations governed by a board of directors elected by members of the cooperative. Units of State or local governments would be permitted to form a cooperative. Insurers would be prohibited from forming a cooperative, but would be permitted to administer one. Cooperatives would be eligible for Federal tax-exempt status (subject to rules concerning private inurement, lobbying and political activity restrictions).

G. DUTIES OF COOPERATIVES

Duties of cooperatives would include: entering into agreements with certified health plans, employers, and individuals; collecting and forwarding premiums to certified health plans; coordinating with other cooperatives; and providing a complaint process regarding cooperative actions. Cooperatives would be expressly prohibited from approving or enforcing provider payment rates, performing any activity relating to premium payment rates, and bearing insurance risk.

Cooperatives would be required to report to the State such information regarding marketing, enrollment and administrative expenses as required by the Secretary. The Secretary would be required to promulgate rules regarding fiduciary responsibilities of cooperatives.

H. FEDERAL EMPLOYEES HEALTH BENEFITS (FEHB) PROGRAM

All health plans participating in the Federal Employees Health Benefits Program would be required to offer coverage in the community-rated market in the areas in which they operate. Non-federal employee purchasers would pay the local community rate for that plan, and would not be a part of the FEHB insurance pool. Government-wide FEHB plans would not be required to open to non-federal employee enrollment.

Effective Date

January 1, 1996.

VI. COST CONTAINMENT

A. PREMIUM TARGETS

Present Law

No provision.

Description of Proposal

1. National Health Care Commission

The Commission (established under Part II of this document) would monitor the change in per-capita health insurance premiums for certified health plans.

2. Premium Targets

Targets for changes in per-capita premiums would be set in law as the projected percentage increase in the CPI-U, plus a percentage increment reflecting three factors: (1) increases in real per-capita income, (2) changes in demographics and health status indicators, and (3) changes in medical technology and the use of services. The premium targets' increments over CPI-U would be the following:

For 1996, 4.0 percentage points;
For 1997, 3.5 percentage points;
For 1998, 3.0 percentage points;
For 1999, 2.5 percentage points;
For 2000 and thereafter, 2.0 percentage points.

3. Functions of Commission

On February 15, 1997, and each February 15 thereafter through 2005, the Commission would report to the Congress and the President on the increase in per capita premiums. If the Commission finds that premiums during the prior calendar year increased at a rate in excess of the targets (adjusted to reflect the actual increase in the CPI-U), the Commission would be required to make appropriate recommendations to the Congress on measures to keep premium costs within the targets.

The Congress would be required to consider the recommendations of the Commission under expedited procedures. The proposals, upon transmittal to Congress, would be drafted as a joint resolution by House Legislative Counsel, in consultation with Senate Legislative Counsel, and would be introduced by the Majority Leaders of the Senate and House of Representatives, for themselves and the respective Minority Leaders by March 15. Committees would have 45 session days to report the resolution or be discharged. Committees may report amendments relevant to cost

containment. Three days after the measure is placed on the calendar, any Member could make a non-debatable motion to proceed to the resolution. Motions to proceed would be non-debatable. If the motion to proceed is agreed to, consideration of the resolution would proceed under a 50-hour time limitation and amendments relevant to cost containment would be in order. At the expiration of the 50 hours, a vote on final passage of the resolution would occur. Debate on conference agreements would be limited to 20 hours.

Effective Date

Upon enactment.

B. BUDGET CONTROL: PAY-AS-YOU-GO FAILSAFE

Present Law

Congress enacted the Gramm-Rudman-Hollings Act (Pub. L. No. 99-177) in late 1985, to provide an incentive for the President and Congress to reduce the deficit each year through the regular legislative process. The Gramm-Rudman-Hollings Act established a declining series of deficit targets (referred to as "maximum deficit amounts") leading to a balanced budget in fiscal year 1991. The Act enforced the deficit targets by the "sequestration process," under which automatic spending reductions would occur if the projected deficit exceeded the deficit targets.

In 1987, after the Supreme Court ruled the sequestration triggering mechanism in the Gramm-Rudman-Hollings Act unconstitutional due to Legislative Branch involvement, Congress amended the Act, extending the goal of a balanced budget to fiscal year 1993 and placing responsibility for the automatic triggering of sequestration in the hands of the Director of the Office of Management and Budget (OMB).

Congress revised the sequestration process in the Budget Enforcement Act (BEA) of 1990. First, the Act extended the process through fiscal year 1995 (although the budget was not required to be balanced by that time). Second, the Act shifted the focus of deficit control away from overall deficit reduction targets, to a policy requiring that new Federal legislation not increase Federal deficits. This pay-as-you-go requirement was accomplished by establishing: (1) discretionary spending caps which effectively require that new or increased discretionary spending be offset by decreases in other discretionary programs; and (2) a pay-as-you-go (PAY-GO) requirement to ensure that legislative changes in entitlement spending and revenues are fully paid for. The BEA made the spending caps and PAY-GO requirement enforceable by sequestration (i.e. automatic budget reductions). Congress extended the spending caps and the PAY-GO requirement through fiscal year 1998 in the Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66.

The pay-as-you-go policy was strengthened in the FY 1994 and FY 1995 concurrent resolutions on the budget, which imposed a 10-year pay-as-you-go

requirement on entitlement and revenue legislation considered by the Senate. Legislation violating the requirement is subject to a point of order, which may only be waived by a supermajority of 60 votes.

The existing statutory PAY-GO constraints through FY 1998 and the Senate's 10-year pay-as-you-go point of order, operate to prevent the enactment of legislation which is projected at the time of enactment to cause increases in the deficit for any year through fiscal year 2004.

Description of Proposal

This proposal would establish a mechanism for mid-course corrections in the event of increases in the deficit attributable to health care reform.

1. Timetable for pay-as-you-go mechanism

January/February - In the years 1997, 1999, 2001, 2003 and 2005, five days prior to the President's budget submission, CBO is required to submit to the Congress and OMB a determination of whether health reform has caused an increase in the deficit in the prior year. Five days later, the President's Budget for the fiscal year is to include OMB's determination of whether health care reform caused a deficit increase in the prior fiscal year. OMB must explain any differences from CBO's preliminary determinations. If a deficit increase is attributed to health care reform, automatic and proportional reductions in: (1) subsidies and (2) the tax credit for insurance premiums paid by the self-employed and individuals not covered at work, go into effect September 20 unless alternative deficit reduction legislation is enacted prior to that time.

June 1 - Deadline for the President to submit to the Congress an alternative deficit reduction resolution, which offsets the deficit increase attributable to health care reforms.

June 10 - CBO to report to the Senate and House Budget Committees on whether the alternative deficit reduction resolution submitted by the President will produce the same amount of deficit reduction in the upcoming fiscal year as is required to be achieved through automatic reductions. If the Chairmen of the Senate and House Budget Committees certify that the alternative deficit reduction resolution produces the required deficit reduction, it is protected by fast-track procedures, as follows.

June 15 - Deadline for the Majority Leaders of the House of Representatives and the Senate to introduce alternative deficit reduction legislation. Legislation to be referred to all relevant committees. Committees are to review the legislation, but no amendments are permitted.

June 25 - House committees discharged of alternative deficit reduction legislation if they have not reported.

July 1 - If no real economic growth in the two most recent quarters,

the Chairman of the Council of Economic Advisers is to make a "no-growth" report which suspends the subsidy reductions and congressional alternative deficit reduction fast-track.

July 10 - Deadline for House of Representatives to vote on alternative deficit reduction legislation. Bill may not be amended; debate limited to 20 hours, equally divided.

July 20 - Senate committees discharged if they have not reported bill received from the House.

August 5 - Deadline for Senate vote on alternative deficit reduction legislation. Bill may not be amended; debate limited to 20 hours, equally divided.

September 20 - If OMB made a determination in the President's budget that the deficit increased in the prior fiscal year due to health care reform, and if alternative deficit reduction legislation has not been enacted into law, then proportional reductions in: (1) subsidies and (2) the tax credit for insurance premiums paid by the self-employed and individuals not covered at work, go into effect.

November 1 - GAO audit of automatic reductions, or implementation of alternative deficit reduction legislation, as the case may be.

January/February - CBO report to Congress on success of automatic reductions or alternative deficit reduction legislation in eliminating health care deficit.

2. Entitlement to subsidies and certain tax deductions made contingent on automatic deficit reduction

The legal entitlement to subsidies and the tax credit for insurance premiums paid by the self-employed and individuals not covered at work, would be subject to the operation of the back-up deficit reduction mechanism explained below.

3. Preparation of "pre-health care reform baseline"

CBO and OMB would be required, within 60 days following enactment, to prepare a baseline for total Federal health care expenditures, projected for each fiscal year through 2004, as would have occurred without the enactment of health care reform. CBO shall transmit its estimates to the Congress and OMB within 30 days of enactment. Five days after CBO's transmittal, OMB shall transmit to the Congress its determinations, explaining in detail any differences from CBO's estimates.

4. Determination of deficit increase

In calendar years 1997, 1999, 2001, 2003 and 2005, five days prior to the President's budget submission, CBO is required to submit to the Congress and the OMB estimates of whether health care reform has caused an increase in the deficit in the prior fiscal year. Five days later, the President's annual Budget for the upcoming fiscal year is to include OMB's determination of whether health care reform caused a deficit increase in the prior fiscal year. OMB must explain any differences from CBO's estimates.

In determining whether health care reform "has caused an increase in the deficit for the prior fiscal year," CBO and OMB shall proceed as follows:

a. Determine "total Federal health care spending for the prior fiscal year."

b. Adjust the "pre-health care reform baseline" for Federal spending in the prior fiscal year to reflect all identifiable health care spending variables not attributable to health care reform.

c. Subtract pre-health care reform spending for the prior fiscal year (as adjusted), from total Federal health care spending for the prior fiscal year--producing the "net increase in Federal health care spending for the prior fiscal year."

d. Subtract from the net increase in Federal health care spending, net revenues for the prior fiscal year currently estimated to have resulted from enactment of health care reform. If the "net increase in Federal health care spending" exceeds "net revenues," the difference shall be designated the deficit increase for the prior fiscal year resulting from health care reform legislation.

> **Example of calculation:** In January of 1997, CBO and OMB will determine how much total Federal health care spending was in fiscal year 1996; they will subtract from that total, the amount of pre-health care reform spending which had been projected by OMB for FY 1996 (in the pre-health care reform baseline) as adjusted to exclude increases in spending unrelated to health care; the resulting number will reflect the net increase in Federal health care spending for FY 96 which has resulted from health care reform; finally, the net revenues projected to have been raised in FY 96 due to health care reform are offset against the net spending increase; this yields the FY 96 deficit increase, if any, resulting from health care reform.

5. Determination of Required Deficit Reduction

If OMB has determined that health care reform caused an increase in the deficit in the prior fiscal year, OMB must report in the President's Budget how much deficit reduction is required to be implemented in the upcoming fiscal year. This is to be determined by inflating the amount of deficit increase from the prior fiscal year, using the CPI-U.

For example, suppose that OMB determines in January 1997 that in Fiscal Year 1996, the deficit increased by $10 billion due to health care reform. OMB would then apply the projected inflation rate for FY 97 and FY 98 to the $10 billion deficit increase to determine how much of a deficit offset is required in FY 98. If inflation is estimated to be 3.1 percent in fiscal years 1997 and 1998, the adjusted deficit reduction required for FY 98 would be $10.63 billion.

These determinations would occur every two years, beginning in 1997 and through 2005. This biennial structure would operate to avoid double-counting deficit increases. For example, suppose a determination in 1997 causes an automatic subsidy reduction in FY 98. If there was a deficit determination only one year later in 1998, the "look-back" at FY 97 would fail to capture the effects of the already implemented deficit reduction. However, the biennial process, which calls for a look back in 1999 at FY 98, *will* take into account the implemented deficit reduction under the prior cycle.

6. Determination of Required Reductions

If OMB reports in the President's budget that deficit reduction is required for the upcoming fiscal year to offset a deficit increase resulting from health care reform, the President is required on September 20 to implement proportional reductions in: (1) subsidies and (2) the tax credit for insurance premiums paid by the self-employed and individuals not covered at work--<u>unless</u> alternative deficit reduction legislation is enacted in the interim. The President must report in the Budget for that fiscal year specifically what reductions are to be implemented on September 20.

The required deficit reduction is to be achieved through a progressive formula, so that: (1) subsidies for the lower income recipients would receive the smallest reductions and subsidies for the higher income recipients would receive the largest reductions; and (2) the reduction in the tax credit for insurance premiums paid by the self-employed and individuals not covered at work would be applied progressively, based on income.

7. Alternative Deficit Reduction Legislation

A procedure is established for fast-track consideration of a legislative alternative to the automatic reductions. If OMB determines a deficit increase attributable to health care reform for the prior fiscal year, the President would be required to submit to Congress by June 1: (1) alternative deficit reduction legislation designed to achieve the required deficit reduction for the upcoming fiscal year; or (2) a report explaining why such alternative legislation is not being transmitted.

It is expected that the alternative deficit reduction legislation would be developed through a process similar to the trade fast-track

process used for the implementing bills for the North American Free Trade Agreement and the Uruguay Round of the General Agreement on Tariffs and Trade. Those processes have involved extensive consultation among the Senate and House committees of jurisdiction through "mock mark-ups and conferences," as well as extensive consultation with the Executive Branch.

The alternative deficit reduction legislation is to be submitted as a joint resolution stating in the resolving clause that the "Congress has determined that it is necessary to avert automatic reductions in Federal health care subsidies by enacting the following changes in law, which are estimated to eliminate projected deficit increases resulting from the enactment of health care reform."

If alternative deficit reduction legislation is transmitted to the Congress, CBO is to report to the Senate and House of Representatives by June 10, estimates of whether the alternative deficit reduction language submitted by the President will produce the same amount of deficit reduction in the upcoming fiscal year as is required to be achieved through automatic reductions (as estimated by OMB). If the Chairmen of the Senate and House Budget Committees certify by June 13, that the alternative deficit reduction legislation produces the required amount of deficit reduction, it will proceed through the Congress under the following procedural "fast-track" protections.

8. Fast-Track Procedures

Introduction of Resolution.--Under the fast-track procedure, the Majority Leaders of the House of Representatives and the Senate are required, no later than June 15, to introduce the alternative deficit reduction legislation, transmitted by the President, on behalf of themselves and the respective Minority Leaders.

Referral.--The legislation is to be referred to all relevant committees. Committees are to review the legislation, but no committee amendments are permitted.

Discharge.--On June 25, House committees are to be discharged of alternative deficit reduction legislation if they have not yet reported.

Vote by House of Representatives.--The House of Representatives must vote on the alternative deficit reduction legislation no later than July 10. During consideration by the House of Representatives, the bill may not be amended and debate is limited to 20 hours.

Discharge by Senate Committees.--If alternative deficit reduction legislation passes the House of Representatives, all Senate committees to which the legislation was referred are discharged no later than July 20 if they have not reported the legislation.

Vote by Senate.--The Senate must vote on the alternative deficit reduction legislation no later than August 5. During consideration by the

Senate, the bill may not be amended and debate on the bill (and all motions and appeals) is limited to 20 hours, equally divided between the Majority and Minority Leaders or their designees. A motion to proceed to the alternative deficit reduction legislation is non-debatable. Motions to recommit the alternative deficit reduction legislation are not in order. Section 313 of the Congressional Budget and Impoundment Control Act of 1974, commonly known as the "Byrd Rule," would apply in the Senate so that any "non-budgetary" provisions included in the alternative deficit reduction legislation, as submitted by the President, could be stricken from the bill.

9. Implementation of Deficit Reduction

If alternative deficit reduction legislation has not been enacted by September 20: (1) the President is required to implement automatic reductions in subsidies by executive order; and (2) the Secretary of the Treasury is required to promulgate regulations reducing the tax credit for insurance premiums paid by the self-employed and individuals not covered at work.

10. No-growth suspension

No later than July 1, the Chairman of the Council of Economic Advisers (CEA) shall make a "no-growth" report to the President and the Congress, if the Commerce Department has reported less than zero percent real economic growth for the fourth quarter of the preceding calendar year and the first quarter of the current calendar year. If the CEA Chairman makes a no-growth report to the President and the Congress: (1) the President shall not issue an executive order implementing across-the-board reductions in subsidies and the Secretary of the Treasury shall not issue Treasury regulations reducing tax credits; and (2) the fast-track procedures in the Congress shall be automatically suspended. If an alternative deficit reduction resolution is in the fast-track process when a no-growth report is issued, legislative consideration may continue, but without the expedited procedures of the fast-track.

11. GAO Audit of Reductions

If alternative deficit reduction legislation has been enacted, or if the President has issued an executive order and the Secretary of the Treasury has issued regulations imposing the required reductions, the General Accounting Office is required to report to Congress no later than November 1: (1) in the case of an executive order and Treasury regulations, an analysis of whether the reductions have been implemented according to statutory requirements; or (2) if alternative deficit reduction legislation has been enacted, an analysis of whether the reductions have been implemented as required in the statute.

12. CBO Report

If alternative deficit reduction legislation has been enacted, or if the President has issued an executive order and the Secretary of Treasury has issued regulations making required reductions, the Congressional Budget Office must include in its January publication of the Economic and Budget Outlook, an analysis of whether the reductions are likely to be successful in eliminating the deficit overage.

Effective Date

Upon enactment.

C. MALPRACTICE REFORMS

Present Law

No provision.

Description of Proposal

1. Alternative Dispute Resolution (ADR) Procedures

Health plans would be required to establish ADR procedures and malpractice claims could not be brought in court until the claims had gone through and reached a final resolution under the plan's procedures. Each health plan would be required to adopt at least one of the specified dispute resolution methods for resolving medical malpractice claims arising from the provision of health care services to individuals enrolled in the plan. Acceptable ADR procedures would include arbitration; required mediation; and a process requiring parties to make early offers of settlement.

2. Actions in State Courts

After final resolution of an enrollee's claim under an ADR procedure, an enrollee dissatisfied with the resolution would be permitted to bring a cause of action to seek damages or other redress with respect to that claim, to the extent permitted under State law.

3. Contingency Fee Limits

Contingency fees paid to attorneys would be limited to a sliding-scale schedule. An attorney who represents a plaintiff in a medical malpractice action on a contingency fee basis would not be permitted to charge, demand, receive or collect more than a specified percentage of the total amount recovered by judgment or settlement in the action. This limitation would also apply to proceedings under any ADR procedure.

4. Collateral Source Offsets

Awards would be reduced by the amount of any payment for the same injury from another source. The reduction in damages would take into account the amount of past or future payment that the individual has received, or is eligible to receive, from other sources. Such sources include Federal or State disability or sickness programs; Federal, State or private health insurance programs; private disability insurance programs; employer wage continuation programs; and any other program, if the payment is intended to compensate the claimant for the same injury for which damages are awarded.

5. Periodic Payments

Payments of over $100,000 could be made on a periodic schedule determined by the court. At the request of any party to a medical malpractice liability action, the defendant would be permitted to make such payments periodically, based on a schedule that the court considers appropriate, taking into account the periods for which the injured party would need medical and other services.

6. Enterprise Liability Demonstrations

Demonstration projects for limiting liability to health plans rather than physicians would be authorized. The Secretary of Health and Human Services would be required to establish and fund a demonstration project in one or more States to demonstrate whether making the plan in which a physician participates, rather than the physician, liable for the physician's medical malpractice improves the quality of health care provided under the plan, reduces defensive medical practices, and improves risk management. To be eligible to participate in the demonstration project, a State would be required to enter into an agreement with a health plan under which the plan assumes legal liability for malpractice claims arising from the provision or failure to provider services under the plan by any participation physician. The State would also be required to provide by statute that physicians participating in such plans would not be liable for damages and would not be required to indemnify the plan for the value of any awards.

7. Medical Practice Guideline Demonstrations

Demonstration projects for adopting medical practice guidelines as the standard of care in medical liability actions would be authorized. The Secretary of HHS would establish and fund the demonstration projects at the State level. To be eligible to participate, the State would be required to provide assurances that under the law of the State, in a medical malpractice action alleging that the defendant was negligent in providing (or failing to provide) services, the appropriate medical practice guideline would establish the standard of care.

8. Preemption

Federal malpractice reforms 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. The Federal provisions would apply in any malpractice liability action brought in any State or Federal court, with the exception of cases involving claims or actions for damages arising from an injury or death subject to resolution under other Federal laws.

9. No Right to Action in Federal Court

The Federal malpractice provisions would govern actions in State courts and would not establish a basis for bringing malpractice actions in Federal court.

Effective Date

Effective for causes of action arising on or after January 1, 1996.

D. ADMINISTRATIVE SIMPLIFICATION AND PAPERWORK REDUCTION

Present Law

Federal law does not regulate the collection of private sector health information except for Medicare claims, which are collected by the Health Care Financing Administration of the Department of Health and Human Services for a centralized database. The Omnibus Budget Reconciliation Act of 1993 also calls for a data bank of all insurance coverage from any source to be used for coordination of benefits to prevent Medicare and Medicaid from paying claims for which another insurer was responsible. This data bank has not yet been established.

Description of Proposal

1. Purpose

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

2. Requirements for the Secretary of HHS

The Secretary would be required to implement a national health information network by adopting standards for:

(a) representing the content and format of health information in both paper and electronic forms,
(b) transmitting health information over the network,
(c) conducting transactions using this information,
(d) certifying public or private entities to perform the intermediary functions which implement the network, and
(e) monitoring performance to assure compliance.

The Secretary would be required to establish expedited procedures to adopt health information standards that are already in common use or that are recommended by public or private standards setting organizations such as the American National Standards Institute.

The Secretary would be required to establish procedures for:
(a) adding codes to previously adopted standards;
(b) making changes to previously adopted standards; and
(c) developing, testing, and adopting new standards.

3. Establishment of a Health Information Advisory Committee

The Secretary would be required to consult with a Health Information Advisory Committee consisting of 15 members from the private sector including providers, consumers, and experts with practical experience in developing and applying health information and networking standards. The members would be appointed by the President and serve staggered, 5 year terms.

4. Requirements for Health Plans and Health Care Providers

All health plans, including Federal and State health programs, and all health care providers would be required to participate in the health information network either directly or through a contract with a certified health information network service. Plans and providers would be required to conduct transactions electronically over the health information network for:
(a) claims and claims attachments (or encounters in the case of providers who do not submit claims), and
(b) research and quality data inquiries.

In addition, plans would be required to conduct transactions electronically over the health information network for:
(a) enrollment;
(b) eligibility determination;
(c) claims status;
(d) payment and remittance advice;
(e) coordination of benefits;
(f) first report of injury; and
(g) referrals, certification, and authorization.

The Secretary may require other transactions to be conducted electronically, consistent with the goal of reducing administrative costs. In addition, plans and providers would be required to make certain standard data available electronically on the health information network to authorized inquiries.

5. Standards for Accessing Health Information

The Secretary would be required to establish technical standards for requesting standard health information from participants in the health information network which assure that a request for health information is

authorized under the Privacy and Confidentiality Part or that it requests health information that is not protected under the Privacy and Confidentiality Part because individuals cannot be identified using the information requested.

The Secretary would be required to establish standards for the appropriate release of health information to researchers and government agencies, including public health agencies. The Secretary would establish standards for the electronic identification of a request as one which comes from a person authorized to receive the requested health information under the Part on Privacy and Confidentiality.

6. Preemption of State "Quill Pen" Laws

Requirements of this Part would preempt State laws which conflict, including provisions that require health records to be maintained in written, rather than electronic, form. The Secretary would be required to establish standards for an electronic identifier which would serve the same function as a signature and its use would supersede State laws requiring a written signature.

7. Health Security Cards

The Secretary would be required to determine a standard format for a health security card which includes a form of the social security number to uniquely identify each individual. Using this standard, health plans will issue cards to individual enrollees.

8. Penalty for Failure to Comply

All participants would be required to comply with this section within a reasonable time unless specifically excluded or waived. The Secretary would be required to impose a penalty of not more than $1,000 for each violation of health information network standards and requirements. Additional penalties would be imposed for violation of the Part on Privacy and Confidentiality.

9. Health Information Continuity

To prevent the loss of health information due to bankruptcy of a health information network participant, the Secretary would be required to establish procedures for the rescue and reassignment of information held by participants who cease to function or who function in a manner that would threaten the continuous availability of their information.

10. Demonstration Projects for New Applications

The Secretary would be authorized to make grants for demonstration projects to promote the development and use of electronically integrated, community-based clinical information systems and computerized patient record systems.

11. Replacement of Medicare and Medicaid Coverage Data Bank

The function of the Medicare and Medicaid Coverage Data Bank would be replaced through the requirement on all health plans to ensure the electronic availability on the health information network of standardized enrollment and eligibility information on every covered individual.

In order to be certified, health information network services would be required to be capable of performing automated electronic coordination of benefits and responding to queries from health care providers and health plans, in standardized transactions as defined by the Secretary, regarding the enrollment and coverage for any individual under any health plan.

Effective Date

Upon enactment.

E. FRAUD

Present Law

1. Sanctions for Fraud that Affects Federal Outlays

Title XI of the Social Security Act provides penalties for health care fraud and abuse within the Medicare and Medicaid programs. These penalties include exclusion from participation in the programs and the imposition of civil monetary penalties and criminal penalties. The Office of the Inspector General of HHS and the Attorney General are responsible for investigating and prosecuting such violations. State agencies also provide health care fraud control programs to restrict fraud and abuse within the Medicaid program.

2. Health Care Anti-Fraud Trust Fund

No provision.

Description of Proposal

1. Sanctions for Fraud that Affects Federal Outlays

a. The Secretary of HHS would be required to exclude from participation in a health plan for not less than five years an individual or entity convicted of violations described in section 1128(a) of the Social Security Act, as amended to include actions affecting Federal outlays under this Act. The Secretary would be authorized to exclude from participation in a health plan for periods of different duration an individual or entity convicted of violations described in specified subsections of section 1128(b) of the Social Security Act, as amended. The Secretary would be required to provide notice of exclusions to health plans, State health care administrative agencies, and State licensing agencies. Requirements with respect to notice, hearings, and judicial review of exclusions would be established.

b. The Secretary of HHS would be authorized to impose civil monetary penalties for actions affecting Federal outlays, including ones that are similar to those that would subject a person to a penalty under specific provisions of section 1128A of the Social Security Act. The Secretary would generally follow procedures and provide for appeals as would be required for similar proceedings under section 1128A of the Social Security Act, or the State in which the plan is located could initiate such a proceeding.

c. A number of related amendments would be made to conform and strengthen the anti-fraud and abuse provisions under the Social Security Act.

2. Health Care Anti-Fraud Trust Fund

A health care anti-fraud trust fund would be created with a portion of administrative penalties and assessments imposed under the Social Security act, civil monetary penalties imposed under this Act, and other penalties paid for related violations and actions. Amounts in the trust fund would be available without appropriation and could be used by the Secretary and the Attorney General to cover the costs of combatting fraud affecting Federal outlays. Such funds would be supplementary to appropriated operating budgets of the agencies.

Effective Date

January 1, 1996.

VII. REVENUE PROVISIONS

A. INCREASE IN EXCISE TAXES ON TOBACCO PRODUCTS

Present Law

1. Tax rates

Excise taxes are imposed on the manufacture or importation of cigarettes, cigarette papers and tubes, snuff, chewing tobacco, and pipe tobacco. The present-law tax rates are as follows:

Cigarettes	
Small cigarettes (weighing no more than 3 pounds per thousand)[1]	$12 per thousand (i.e., 24 cents per pack of 20 cigarettes)
Large cigarettes (weighing more than 3 pounds per thousand)[2]	$25.20 per thousand
Cigars	
Small cigars (weighing no more than 3 pounds per thousand)	$1.125 per thousand
Large cigars (weighing more than 3 pounds per thousand)	12.75 percent of manufacturer's price (but not more than $30 per thousand)
Cigarette papers and tubes	
Cigarette papers[3]	0.75 cent per 50 papers

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[1] Most taxable cigarettes are small cigarettes.

[2] Large cigarettes (measuring more than 6-1/2 inches in length) are taxed at the rate prescribed for small cigarettes, counting each 2-3/4 inches (or fraction thereof) as one cigarette.

[3] Cigarette papers measuring more than 6-1/2 inches in length are taxed at the rate prescribed, counting each 2-3/4 inches (or fraction thereof) as one cigarette paper. No tax is

Cigarette tubes[4]..... 1.5 cents per 50 tubes

Snuff, chewing tobacco, pipe tobacco

Snuff..... 36 cents per pound

Chewing tobacco..... 12 cents per pound

Pipe tobacco..... 67.5 cents per pound

2. Exemptions; use of revenues

No tax is imposed on tobacco products exported from the United States. Exemptions also are allowed for (1) tobacco products furnished by manufacturers for employee use or experimental purposes; and (2) tobacco products to be used by the United States. In addition, no tax is imposed on tobacco to be used in "roll-your-own" cigarettes.

Revenues from the tobacco products excise taxes are retained in the general fund of the Treasury. Revenues from taxes on tobacco products brought into the United States from Puerto Rico and the American Virgin Islands are transferred ("covered over") to those possessions if the products satisfy a domestic content requirement with respect to the possession from which they are received.

Description of Proposal

1. Rate increases; extension of coverage

The proposal would increase the tax rate on small cigarettes by $88.00 per thousand ($1.76 per pack of 20 cigarettes) and on large cigarettes by $184.80 per thousand. The tax on other currently taxable tobacco products generally would be increased by $29.33 per pound of tobacco content and a $29.33 per pound tax would be imposed on "roll-your-own" tobacco.

The new tax rates on tobacco products would be--

Cigarettes

Small cigarettes (weighing no more than 3 pounds per thousand)..... $100.00 per thousand (i.e., $2.00 per pack of 20 cigarettes).

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imposed on a book or set of cigarette papers containing 25 or fewer papers.

[4] Cigarette tubes measuring more than 6-1/2 inches in length are taxed at the rate prescribed, counting each 2-3/4 inches (or fraction thereof) as one cigarette tube.

Large cigarettes (weighing more than 3 pounds per thousand).....	$210.00 per thousand.
Cigars	
Small cigars (weighing no more than 3 pounds per thousand).....	$89.13 per thousand.
Large cigars (weighing more than 3 pounds per thousand).....	106.21 percent of manufacturer's price (but not more than $249.90 per thousand).
Cigarette papers and tubes	
Cigarette papers.....	6.25 cents per 50 papers.
Cigarette tubes.....	12.50 cents per 50 tubes.
Snuff, chewing tobacco, pipe tobacco, "roll-your-own" tobacco	
Snuff.....	$29.69 per pound
Chewing tobacco.....	$29.45 per pound
Pipe tobacco.....	$30.00 per pound
"Roll-your-own" tobacco...	$29.33 per pound

Revenues from the increase in excise taxes on tobacco products provided for in the proposal would be paid into the Health Security Trust Fund.

The proposal would impose the increase in the excise tax rate on tobacco products to such products in Puerto Rico. Revenues from these taxes also would be paid into the Health Security Trust Fund.

2. Exemptions; administrative provisions

The proposal would repeal the present-law exemptions for tobacco products provided to employees of the manufacturer and for use by the United States, and would include administrative and compliance provisions. These provisions would--

(1) Limit the exemption for exports to products that are marked or

labelled under Treasury Department rules designed to prevent the diversion of such products into the domestic market.

(2) Prohibit the re-importation of tobacco products previously exported without payment of tax (other than for return to the manufacturer) and impose a new penalty, equal to the greater of $1,000 or five times the amount of tax on all parties involved in any prohibited re-importation. (All tobacco products and cigarette papers and tubes, as well as all vessels, vehicles, and aircraft used in such re-importations, would be subject to seizure by the United States.)

(3) Extend current manufacturer inventory maintenance, reporting requirements, criminal penalties, and forfeiture rules to importers of tobacco products.

(4) Repeal the present-law exemption for books or set of cigarette papers containing 25 or fewer papers.

(5) Limit the cover over of tobacco product revenues to Puerto Rico and the Virgin Islands to present-law tax levels.

Effective Date

The proposal generally would be effective for tobacco products removed after December 31, 1994. A floor stocks tax would be imposed on taxed tobacco products held on January 1, 1995.

B. ADDITIONAL MEDICARE PART B PREMIUMS FOR HIGH-INCOME INDIVIDUALS

Present Law

Medicare, authorized under Title XVIII of the Social Security Act, is a nationwide health insurance program for the aged and certain disabled persons. It consists of two parts: the hospital insurance (Part A) program and the supplementary medical insurance (Part B) program.

Most Americans age 65 or older are automatically entitled to coverage under Part A of Medicare. Part B of Medicare is voluntary. All persons age 65 or older may elect to enroll in Part B of Medicare by paying a flat monthly premium. The flat premium for 1994 is $41.10 per month. The premium rate is equal to 25 percent of estimated program costs for the coming year. Each individual who enrolls in Medicare Part B pays the same premium regardless of his or her income level. Benefits received under Part A and Part B of Medicare are excludable from the gross income of the recipient.

Description of Proposal

Under the proposal, taxpayers with modified adjusted gross income (AGI) above a threshold amount would be required to pay additional premiums for each month of coverage under Part B of Medicare. The maximum Medicare

Part B premium for high-income Medicare Part B enrollees would cover approximately 75 percent of estimated program costs, up from the current level of 25 percent.

For the purpose of these additional premiums, modified AGI would be AGI plus tax-exempt interest, certain foreign source income, and income from higher education U.S. savings bonds. The threshold amount would be $90,000 for unmarried taxpayers, $115,000 for married taxpayers filing joint returns, and $0 for married taxpayers filing separate returns. The amount of additional premiums would be phased in for taxpayers with modified AGI which exceeds the threshold amount by less than $15,000 ($30,000 for married taxpayers filing joint returns if each spouse is required to pay additional premiums).

Any additional Medicare Part B premiums imposed under this proposal would be treated as income taxes for purposes of subtitle F of the Code (relating to income tax procedure and administration) but would not be treated as income taxes for alternative minimum tax purposes (Code sec. 55), or for the purpose of determining the amount of other tax credits under the Code. Further, additional premiums imposed under this proposal would be deductible to the extent the premiums, when added to other medical expenses not otherwise deductible, exceed 7.5 percent of AGI.

Under the proposal, penalties for failure to pay estimated income tax would not be imposed on a taxpayer for any period prior to April 16, 1997, to the extent that the underpayment resulted from the failure to pay additional Medicare Part B premiums.

Proceeds from the collection of additional Medicare Part B premiums would be credited at least quarterly to the Supplemental Medical Insurance Trust Fund.

Effective Date

The proposal would be effective for taxable years beginning after December 31, 1995.

C. MODIFICATION TO SELF-EMPLOYMENT TAX TREATMENT OF CERTAIN S CORPORATION SHAREHOLDERS AND PARTNERS

Present Law

1. Employment taxes, in general

As part of the Federal Insurance Contributions Act (FICA), a tax is imposed on employees and employers up to a maximum amount of employee wages. The tax is composed of two parts: old-age, survivor, and disability insurance (OASDI) and Medicare hospital insurance (HI). For wages paid in 1993 to covered employees, the OASDI tax rate was 6.2 percent on both the employer and employee on the first $57,600 of wages and the HI tax rate was 1.45 percent on both the employer and employee on the first $135,000 of

wages. The cap on wages subject to the OASDI portion of FICA taxes is indexed to changes in the average wages in the economy. The cap on wages subject to the HI tax was repealed for wages and income received after December 31, 1993.

Similarly, under the Self-Employment Contributions Act (SECA), a tax is imposed on an individual's net earnings from self-employment (NESE). The SECA tax rate is the same as the total FICA rates for employers and employees (i.e., 12.4 percent for OASDI and 2.9 percent for HI) and the SECA base is capped and indexed in the same manner as is the FICA base. In general, the SECA tax is reduced to the extent the individual had wages for which FICA taxes were withheld during the year.

2. Treatment of partners and S corporation shareholders

The NESE of a partner in a partnership generally is the partner's distributive share from any trade or business of the partnership, adjusted for certain items of income that are passive in nature (e.g., rentals of real estate, dividends, and interest are excluded from NESE unless such amounts are received in the course of a trade or business of a dealer in the related property). However, the distributive share of a limited partner generally is excluded from NESE except to the extent the distributive share is a guaranteed payment for services actually rendered to or on behalf of the partnership.

Similar rules are not provided for shareholders in S corporations. Thus, shareholders are not required to include as NESE their pro rata share of the income of an S corporation. Rather, shareholders who perform services for the S corporation are subject to FICA taxes on the wages paid to them.[5]

Description of Proposal

1. In general

The proposal would: (1) amend the definition of NESE to include eighty percent of certain S corporation income of shareholder-service providers owning more than two percent of the stock of the S corporation; (2) modify the NESE rules applicable to limited partners in a partnership; and (3)

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[5] Furthermore, a shareholder of an S corporation may be subject to FICA tax even if the shareholder is not paid amounts denominated as "wages" by the corporation. In Rev. Rul. 74-44, 1974-1 C.B. 287, the IRS held that two shareholders who performed services for an S corporation but did not draw salaries were subject to FICA tax on dividend distributions from the corporation because the dividends represented reasonable compensation for the services performed. See, also, Spicer Accounting, Inc. v. U.S., 918 F2d 90 (9th Cir. 1990) and Dunn & Clark, P.A. v. U.S., No. CV 93-0108-E-EJL, (DC Idaho, 3/25/94) for similar results.

provide a special SECA exclusion for certain income derived from inventory for all taxpayers.

2. S corporation shareholders

Under the proposal, in the case of a "2-percent shareholder" of an S corporation for any taxable year who provides significant services to or on behalf of the corporation during the year, NESE would include 80 percent of the shareholder's pro rata share of taxable income or loss from "service-related businesses" carried on by the S corporation. A "2-percent shareholder" would be any shareholder that owns more than 2 percent of the stock of an S corporation at any time during the year (sec. 1372(b)). The shareholder's pro rata share of the income or loss of an S corporation would be determined pursuant to the general rules of subchapter S (sec. 1366). A "service-related business" would be any trade or business involving the performance of services in the fields of health (other than with respect to in-patient personal care facilities), law, engineering, architecture, accounting, actuarial services, performing arts, consulting, athletics, financial services (other than lending or brokerage services), or any trade or business where the Secretary of the Treasury determines that capital is an insignificant income-producing factor for the trade or business.

The present-law exclusions from NESE for certain passive income that apply to sole proprietors and partnerships would also apply to S corporations.

3. Limited partners

In the case of a limited partner of a partnership who provides significant services to or on behalf of the partnership during the year, NESE would include 80 percent of the partner's distributive share (other than guaranteed payments for services) of taxable income or loss from service-related businesses (as defined above) carried on by the partnership. The proposal would retain the present-law guaranteed payment rule for limited partners who provide services to or on behalf of the partnership. Thus, a limited partner who provides significant services to or on behalf of the partnership during the year would include in NESE: (1) 100 percent of any guaranteed payments received for services plus (2) 80 percent of any remaining distributive share of taxable income from service-related businesses carried on by the partnership.

4. Inventory income

The proposal would allow a taxpayer to reduce his or her NESE for the taxable year by a percentage of the lesser of: (1) the amount of the taxpayer's allocable share of inventory income or (2) the amount that the taxpayer's NESE for the year exceeds $135,000. For this purpose, "inventory income" generally would be gross profit from the sale of inventory, less the appropriate trade or business expenses allocable to such activity. In the case of a dealer in securities (as defined in sec. 475), inventory income generally would include interest, dividends, and

other income with respect to securities held as inventory (as generally defined in sec. 475). The $135,000 amount would be reduced by the amount of the taxpayer's wages that are subject to FICA and would be indexed to changes in the average wages in the economy.

5. Other

The proposal would make conforming amendments to the Social Security Act.

The proposal is not intended to change the present-law authority of the Internal Revenue Service to ascertain the reasonable compensation derived by a self-employed taxpayer (or a shareholder-employee) from his or her trade or business (or the trade or business of his or corporation) for payroll tax purposes.

Effective Date

The proposal would apply to taxable years of individuals beginning after December 31, 1995, and to taxable years of S corporations and partnerships ending with or within such taxable years of individuals.

D. EXTENDING MEDICARE COVERAGE OF, AND APPLICATION OF HOSPITAL INSURANCE TAX TO, ALL STATE AND LOCAL GOVERNMENT EMPLOYEES

Present Law

Under present law, State and local government employees hired before April 1, 1986, are not covered under Medicare unless a voluntary agreement providing for such coverage is in effect. Although the hospital insurance payroll tax does not apply to such employees, they may receive Medicare benefits, for example, through their spouse. Medicare coverage and the hospital insurance payroll tax is mandatory for State and local government employees hired on or after April 1, 1986, and for Federal employees.

For wages paid in 1994 to Medicare-covered employees, the total hospital insurance tax rate is 2.9 percent of total wages. One-half of the hospital insurance tax (1.45 percent) is imposed on the employee and one-half on the employer.

Description of Proposal

The proposal would extend Medicare coverage on a mandatory basis to all employees of State and local governments not otherwise covered under present law, without regard to their dates of hire. These employees and their employers would become liable for the hospital insurance tax, and the employees would earn credit toward Medicare eligibility.

In addition, the service of State and local government employees prior to October 1, 1995, would be considered covered employment for purposes of determining eligibility for Medicare coverage. The Department of the

Treasury would be required to reimburse the Federal Hospital Insurance Trust Fund for additional payments made, administrative expenses incurred, and any interest losses which occur as a result of the recognition of the prior service of State and local government employees for Medicare eligibility purposes.

Effective Date

The proposal would apply to services performed by State and local government employees after September 30, 1995.

E. CREDIT FOR HEALTH INSURANCE COSTS OF INDIVIDUALS NOT ELIGIBLE FOR SUBSIDIZED EMPLOYER-PROVIDED HEALTH CARE

Present Law

Under present law, individuals who itemize deductions may deduct amounts paid during the taxable year (if not reimbursed by insurance or otherwise) for medical care of the taxpayer, or the taxpayer's spouse and dependents, to the extent that the total of such expenses exceeds 7.5 percent of the taxpayer's adjusted gross income (AGI). For purposes of the deduction, medical care generally includes insurance premiums, as well as out-of-pocket medical expenses.

In addition, under present law, self-employed individuals cannot exclude the cost of health insurance from gross income. For this purpose, self-employed individuals include sole proprietors, partners in partnerships, and more than 2-percent shareholders of S corporations. Prior to January 1, 1994, a self-employed individual could deduct from gross income 25 percent of the health insurance costs of the individual and his or her spouse or dependents. The 25-percent deduction was not available for any month if the self-employed individual was eligible for employer-paid (i.e., employer subsidized) health benefits under a plan of an employer of the individual or the individual's spouse. In addition, no deduction was available to the extent that the deduction exceeded the taxpayer's earned income.

Description of Proposal

1. In general

The proposal would extend the 25-percent deduction for health insurance expenses of self-employed individuals, effective for taxable years beginning after December 31, 1993. For taxable years beginning on or after January 1, 1996, the proposal would provide a nonrefundable tax credit for health insurance costs of individuals (including self-employed individuals) who do not have employer-subsidized health coverage.

2. Credit for health insurance costs

The credit would equal 15 percent of premiums, net of any government

subsidies, paid by an individual (including a self-employed individual) for health insurance for the individual, or the individual's spouse or dependents, with respect to a certified standard health plan. In the case of an individual in the 15 percent rate bracket, the 15- percent credit is equivalent to a deduction for 100 percent of premiums. The credit is equivalent to a deduction for more than 50 percent of premiums in the case of an individual in the 28 percent rate bracket.

The credit would apply only to the cost of insurance with respect to a certified standard health plan. Thus, uninsured and out-of-pocket medical expenses (e.g., copayments, deductibles, and uncovered expenses), and premiums paid for supplemental or other nonstandard health insurance, would not be eligible for the credit, but would be deductible to the extent that total medical expenses exceed 7.5 percent of AGI. Expenses that are eligible for the credit would not be taken into account for purposes of determining whether total medical expenses exceed the 7.5 percent floor.

The credit would not be available for any month with respect to coverage of an individual if the individual is eligible to participate in a subsidized certified standard health plan maintained by an employer. For example, if an individual is eligible to participate in a subsidized health plan of an employer, but such plan does not offer subsidized coverage of dependents of the individual, then the credit would be available with respect to the purchase of dependent health insurance coverage. In such a case, the credit would apply only with respect to the additional cost of the dependent coverage.

Effective Date

The 25-percent deduction for self-employed individuals would be extended effective for taxable years beginning after December 31, 1993, and before January 1, 1996. The credit for insurance expenses would be effective for taxable years beginning on or after January 1, 1996.

F. LIMITATION ON PREPAYMENT OF MEDICAL INSURANCE PREMIUMS

Present Law

Under present law, individuals who itemize deductions may deduct amounts paid during the taxable year (if not reimbursed by insurance or otherwise) for medical care of the taxpayer, and the taxpayer's spouse and dependents to the extent that the total of such expenses exceeds 7.5 percent of the taxpayer's adjusted gross income (AGI).

Under a special rule, premiums paid during the taxable year by a taxpayer before he or she attains age 65 for insurance covering medical care for the taxpayer, or the taxpayer's spouse or a dependent, after the taxpayer attains age 65 are treated as expenses paid during the taxable year for insurance that constitutes medical care if premiums for the insurance are payable (on a level payment basis) under the contract for a period of 10 years or more or until the year in which the taxpayer attains

age 65 (but in no case for a period of less than five years).

A series of revenue rulings has held that, under certain circumstances, the portion of a fee paid for lifetime care that is properly allocable to medical expenses is deductible in the year paid, even though the medical services will not be performed until a future time, if at all. The Internal Revenue Service has recently issued a revenue ruling stating that the prior rulings should not be interpreted as allowing a current deduction of payments for future medical care (including medical insurance) extending substantially beyond the close of the taxable year in situations where the future care is not purchased in connection with obtaining lifetime care of the type described in the prior rulings. The recent revenue ruling states that it will not be applied to amounts paid before October 14, 1993, or to amounts paid on or after October 14, 1993, pursuant to the terms of a binding contract entered into before that date if such terms were in effect on that date.

Description of Proposal

The proposal would provide that, for purposes of the itemized deduction for medical expenses and the credit for health insurance costs of individuals not eligible for subsidized employer-provided health care, amounts paid during a taxable year that are allocable to insurance coverage or medical care to be provided more than 12 months after the month in which the payment is made would be treated as paid ratably over the period during which the coverage or care is to be provided. The proposal would not amend the special rule under present law for post-age 65 medical insurance.

Effective Date

The proposal would apply to amounts paid after December 31, 1994.

G. DEFINITION OF EMPLOYEE

Present Law

1. In general

In general, the determination of whether an employer-employee or independent contractor relationship exists for Federal tax purposes is made under a common-law test. Under this test, an employer-employee relationship generally exists if the person contracting for the services has the right to control not only the result of the services, but also the means by which that result is accomplished (Treas. Reg. sec. 31.3401(c)-(1)(b)). Whether the requisite control exists is determined based on the facts and circumstances. The Internal Revenue Service (IRS) uses a 20-factor test for this purpose. Rev. Rul. 87-41, 1987-1 C.B. 296. In addition to the common-law test, there are statutory provisions classifying certain employees as employees or independent contractors for certain purposes.

2. Section 530 of the Revenue Act of 1978

In the late 1960s, the IRS increased enforcement of the employment tax laws, and controversies developed between the IRS and taxpayers as to whether businesses had correctly classified certain employees as independent contractors rather than as employees. In response to this problem, Congress enacted section 530 of the Revenue Act of 1978 ("section 530"), which generally permits a taxpayer to treat an individual as not being an employee for employment tax purposes regardless of the individual's actual status under the common-law test, unless the taxpayer has no reasonable basis for such treatment and if certain additional requirements are satisfied. Section 530 does not apply in the case of an individual who, pursuant to an arrangement between the taxpayer and another person, provides services for such other person as an engineer, designer, drafter, computer programmer, systems analyst, or other similarly skilled employee engaged in a similar line of work.

Under section 530, a reasonable basis is deemed to exist for a period if the taxpayer reasonably relied on any of the following: (1) judicial precedent, published rulings, technical advice with respect to the taxpayer, or a letter ruling to the taxpayers; (2) a past IRS audit of the taxpayer in which there was no assessment attributable to the treatment (for employment tax purposes) of the individuals holding positions substantially similar to the position held by the individual in question; or (3) long-standing recognized practice of a significant segment of the industry in which such individual was engaged. These factors are a safe harbor, not the exclusive means of meeting the reasonable basis requirement.

Section 530 does not apply for income tax purposes. Thus, the determination of whether an individual is an employee for income tax purposes is made without regard to section 530.

Section 530 bars the Department of the Treasury (including the IRS) from publishing any regulation or revenue ruling classifying individuals for purposes of employment taxes under interpretations of the common law. Taxpayers may, however, obtain private letter rulings from the IRS regarding the status of employees.

Description of Proposal

The proposal would authorize the Department of the Treasury to issue regulations relating to the classification of workers as employees or independent contractors under the common-law test. Such regulations, which would apply only on a prospective basis, could not have the effect of repealing the ability of any taxpayer to utilize a safe harbor provision contained in section 530 of the Revenue Act of 1978. Thus, any taxpayer who relies on a safe harbor provision of section 530 under present law could continue to do so.

Effective Date

The proposal would be effective on the date of enactment.

H. INCREASE IN PENALTIES FOR FAILURE TO FILE CORRECT INFORMATION RETURNS WITH RESPECT TO NON-EMPLOYEES

Present Law

1. Information reporting requirements

Under sections 6041 and 6041A of the Internal Revenue Code, a person who makes payments of $600 or more to a person during a calendar year for services received in the course of a trade or business generally must file with the Internal Revenue Service (IRS) an information return reporting such payments, and the name, address, and taxpayer identification number of the payee. A similar statement must also be furnished to the payee.

2. Failure to file correct information returns

Any person that fails to file a correct information return with the IRS on or before the prescribed filing date is subject to a penalty that varies based on when, if at all, the correct information return is filed. If a person files a correct information return after the prescribed filing date but on or before the date that is 30 days after the prescribed filing date, the penalty is $15 per return, with a maximum penalty of $75,000 per calendar year. If a person files a correct information return more than 30 days after the prescribed filing date but on or before August 1 of the relevant year, the penalty is $30 per return, with a maximum penalty of $150,000 per calendar year. If a correct information return is not filed on or before August 1 of the relevant year, the amount of the penalty is $50 per return, with a maximum penalty of $250,000 per calendar year.

Special rules are applicable to certain small businesses and to incorrect information returns that are corrected on or before August 1 of the relevant year.

Description of Proposal

The proposal would modify the penalty for failure to file correct information returns under Code sections 6041 and 6041A with respect to services.[6] In general, the proposal would increase the penalty for failure to file correct information returns on or before August 1 of the relevant year from $50 for each return to the greater of $50 or 5 percent of the amount required to be reported correctly but not so reported.

The proposal would also provide an exception to this increase where substantial compliance has occurred. This exception would apply with respect to a calendar year if the aggregate amount that is timely and correctly reported under Code sections 6041 and 6041A with respect to services for that calendar year is at least 97 percent of the aggregate

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[6] The proposal would not apply to information returns required under section 6041 that are not with respect to payments for services.

amount required to be reported under these two sections of the Code for that calendar year. If this exception applies, the penalty of $50 for each return would continue to apply.

Effective Date

The proposal would apply to information returns the due date for which (without regard to extensions) is more than 30 days after the date of enactment.

I. TAX TREATMENT OF ACCELERATED DEATH BENEFITS UNDER LIFE INSURANCE CONTRACTS

Present Law

If a contract meets the definition of a life insurance contract, gross income does not include insurance proceeds that are paid pursuant to the contract by reason of the death of the insured. In addition, the undistributed investment income ("inside buildup") earned on premiums credited under the contract is not subject to current taxation to the owner of the contract. The exclusion from income applies regardless of whether the death benefits are paid as a lump sum or otherwise.

Amounts received under a life insurance contract (other than a modified endowment contract) prior to the death of the insured are includible in the gross income of the recipient to the extent that the amount received exceeds the taxpayer's investment in the contract (generally, the aggregate amount of premiums paid less amounts previously received that were excluded from gross income).

In contrast, if a contract fails to meet the definition of a life insurance contract, inside buildup on the contract is generally subject to tax. To qualify as a life insurance contract for Federal income tax purposes, a contract must be a life insurance contract under the applicable State or foreign law and must satisfy either of two alternative tests: (1) a cash value accumulation test, or (2) a test consisting of a guideline premium requirement and a cash value corridor requirement.

The Treasury Department has issued proposed regulations under which certain "qualified accelerated death benefits" paid to an insured because of his or her terminal illness would be treated as paid by reason of the death of the insured and therefore would qualify for the present-law exclusion from income.[7]

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[7] Under the proposed regulations, a benefit would qualify as a qualified accelerated death benefit only if it meets three requirements. First, the qualified accelerated death benefit can be payable only if the insured becomes terminally ill. Second, the amount of the benefit must equal or exceed the present value of the reduction in the death benefit otherwise payable. Third,

Description of Proposal

The proposal would provide an exclusion from gross income for certain amounts received under a life insurance contract[8] if the insured under the contract is terminally ill. For this purpose, an individual would be considered terminally ill if the insurer determines, after receipt of an acceptable certification by a licensed physician, that the individual has an illness or physical condition that is reasonably expected to result in death within 12 months of the certification.

The exclusion under the proposal would be applicable only if two requirements are met. First, the amount received must equal or exceed the present value of the reduction in the death benefit otherwise payable under the life insurance contract. The present value would be determined by reference to a maximum permissible discount rate,[9] and by assuming that the death benefit would be paid on the date that is 12 months from the date of the physician's certification. Second, the payment of the amount must reduce the cash surrender value and the death benefit payable under the contract proportionately.

The proposal would not apply in the case of a distribution to any taxpayer other than the insured, if such taxpayer has an insurable interest by reason of the insured being an officer or employee of the taxpayer, or

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the payment of the benefit must make a pro rata reduction in the cash surrender value and the death benefit under the policy. For purposes of the proposed regulations, an insured person would be treated as terminally ill if he or she has an illness that, despite appropriate medical care, is reasonably expected to result in death within 12 months from the date of payment of the accelerated death benefit. The proposed regulations would not explicitly require a doctor's certification as to the patient's condition. Under the proposed regulations, the maximum permissible discount rate would be the greater of (1) the applicable Federal rate (AFR) that applies under the discounting rules for property and casualty insurance loss reserves, or (2) the interest rate applicable to policy loans under the contract.

[8] The amount received for this purpose would include an amount received that gives rise to a lien of the issuing company against the contract.

[9] The maximum permissible discount rate would be the highest of the following three government and commercial rates: (1) the 90-day Treasury bill yield, (2) Moody's Corporate Bond Yield Average-Monthly Average Corporates (or any successor rate) for the month ending two months before the date the rate is determined, or (3) the rate used to determine cash surrender values under the contract during the applicable period plus 1 percent per annum.

by reason of the insured being financially interested in any trade or business carried on by the taxpayer.

For life insurance company tax purposes, the proposal would treat a qualified accelerated death benefit rider to a life insurance contract as life insurance.

Effective Date

The proposal generally would apply to amounts received after the date of enactment. A transition rule would provide that the rule determining the present value of the reduction in the death benefit (by reference to a maximum permissible discount rate and a 12-month period) would not apply to any amount received before January 1, 1995. The issuance of a qualified accelerated death benefit rider to a life insurance contract would not be treated as a modification or material change of the contract. The proposal treating a qualified accelerated death benefit rider as life insurance for life insurance company tax purposes would take effect on January 1, 1995.

J. TAX CREDIT FOR THE COST OF PERSONAL ASSISTANCE SERVICES REQUIRED BY INDIVIDUALS

Present Law

There is no tax credit for the costs of personal assistance required by individuals. Certain medical expenses, however, are deductible under section 213. Also, the costs of certain improvements to property may be included in the basis of a taxpayer's property unless it is otherwise deductible under section 213.

Description of Proposal

The proposal would provide a nonrefundable tax credit for up to 50 percent of an individual's personal assistance expenses up to $15,000.

Individuals would be eligible to claim the credit if, by reason of any medically determinable physical impairment, they are unable to engage in any substantial gainful activity without personal assistance in carrying out activities of daily living. Such physical impairment must be expected to result in death or must be expected to last for a continuous period of not less than 12 months. Nonresident aliens would not be eligible to claim the credit.

Personal assistance expenses would include expenses for: (1) personal assistance services appropriate to carry out the activities of daily living in or outside the home, (2) homemaker/chore services incidental to the provision of such personal assistance services, (3) assistance with life skills (in the case of an individual with a cognitive impairment), (4) communication services, (5) work-related support services, (6) coordination of services described in this paragraph, (7) assistive technology and devices (including assessment of need and training for such services), and

(8) modifications to the principal place of abode of the individual. Activities of daily living would be defined to include eating, toileting, transferring, bathing, and dressing.

The maximum annual amount of credit would be the lesser of $7,500 or one-half of the individual's earned income. The amount of the credit would be phased out by providing a lower credit rate for taxpayers with modified adjusted gross income (AGI) of $50,000 or more. The credit rate would be reduced by ten percentage points for each $5,000 of modified AGI, starting at $50,000 of modified AGI. Thus the credit would not be available for individuals with modified AGI of $70,000 or more.

The rate of the credit would be determined as follows —

For taxpayers with modified AGI:	The credit rate would be:
Less than $50,000	50 percent
At least $50,000, but less than $55,000	40 percent
At least $55,000, but less than $60,000	30 percent
At least $60,000, but less than $65,000	20 percent
At least $65,000, but less than $70,000	10 percent
At least $70,000	0 percent

The $15,000 (maximum amount of personal assistance expenditures eligible for the credit) and $50,000 (beginning of the credit's phaseout range) amounts would be indexed for inflation for taxable years beginning after 1996. The amount of modified AGI at which the credit is entirely phased out would not be indexed for inflation, but would always be $20,000 greater than the beginning of the phaseout range.

Modified AGI would mean adjusted gross income: (1) determined without regard to the exclusions provided for (a) interest on education savings bonds (sec. 135), (b) certain foreign earned income of United States citizens or residents living abroad (sec. 911), (c) certain income from sources within Guam, American Samoa, or the Northern Mariana Islands (sec. 931), and (d) income from sources within Puerto Rico (sec. 933); and (2) increased by the amount of tax-exempt interest received or accrued by the taxpayer during the taxable year.

Any amount taken into account in determining the credit could not be taken into account in determining deductible medical expenses (under sec. 213). Similarly, if a credit is allowed for expenses that would otherwise increase the basis of property, the basis increase would be reduced by the amount of the credit. The proposal also would deny the credit for payments to any person related to the taxpayer within the meaning of sections 267 or 707(b).

Effective Date

The proposal would be effective for taxable years beginning after

December 31, 1995.

K. TAX TREATMENT OF ORGANIZATIONS PROVIDING HEALTH CARE SERVICES AND RELATED ORGANIZATIONS

Present Law

1. Exempt status of charities

Code section 501(c)(3) lists certain types of organizations that are exempt from taxation, including those organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes no part of the net earnings of which inures to the benefit of any private shareholder or individual. Contributions to such organizations generally are deductible for Federal income tax purposes. In addition, such organizations are eligible for tax-exempt financing that is not subject to the State volume cap otherwise applicable to private users of tax-exempt financing and, in the case of hospitals, are exempt from the $150 million limit otherwise applicable to the amount of tax-exempt financing from which a section 501(c)(3) organization can benefit.

Although section 501(c)(3) does not specifically mention the furnishing of medical care and the operation of a not-for-profit hospital, such activities have long been considered to further charitable purposes described in section 501(c)(3) if they provide a community benefit (the so-called "community benefit standard"). The community benefit standard is a facts-and-circumstances test that the IRS has applied since 1969, under which a number of factors are examined (e.g., whether a hospital has an open emergency room, a board of directors drawn from the community, an open medical staff, treats Medicare and Medicaid patients, and applies surplus receipts to improving facilities, patient care, and medical education and research) to determine whether the organization provides benefits to the community as a whole rather than serving private interests. The same community benefit standard applies in determining whether a health maintenance organization ("HMO") qualifies for tax-exempt status under section 501(c)(3), although slightly different characteristics are examined.

2. Exempt status of social welfare organizations

Code section 501(c)(4) provides an exemption from income tax for organizations operated primarily to promote the common good and general welfare of the people in the community. Although social welfare organizations are exempt from income tax, contributions to such organizations are not deductible, and such organizations are not eligible to benefit from tax-exempt financing beyond financing available to other private users.

An HMO seeking exemption as a social welfare organization under section 501(c)(4) is not required to possess all of the same characteristics as an HMO that qualifies for exemption under section

501(c)(3); however, its activities must generally satisfy a community benefit standard similar to, but less exacting than, that imposed on charitable HMOs.

3. Private inurement

a. Charities.--Section 501(c)(3) specifically conditions tax-exempt status for all organizations described in that section on the requirement that no part of the net earnings of the organization inures to the benefit of any private shareholder or individual (the so-called "private inurement test").

Organizations described in section 501(c)(3) are classified as either public charities or private foundations. Private foundations (but not public charities) are subject to special penalty excise taxes that may be imposed on "self-dealing" transactions or on expenditures that do not accomplish a charitable purpose. Nonprofit hospitals, and other nonprofit entities the principal purpose or functions of which are providing medical care, automatically are eligible for public-charity status and, thus, are not subject to the special penalty excise taxes.

b. Social welfare organizations.--There is no specific statutory rule prohibiting the net earnings of a social welfare organization described in section 501(c)(4) from inuring to the benefit of a private shareholder or individual.

c. IRS remedy in cases of private inurement.--Because the Code generally does not provide for the imposition of penalty excise taxes in cases where a section 501(c)(3) public charity or a section 501(c)(4) social welfare organization engages in a transaction not furthering a tax-exempt purpose, the only sanction that may be imposed under the Code is revocation of the organization's tax-exempt status.

4. Filing and public disclosure rules applicable to tax-exempt organizations

Tax-exempt organizations generally are required to file an annual information return (Form 990) with the IRS. Code section 6104 requires that a tax-exempt organization (other than a private foundation) make available for public inspection at the organization's principal office a copy of the organization's Form 990 (except for the names of contributors to the organization) for the three most recent taxable years, as well as the organization's application to the IRS for recognition of tax-exempt status.

5. Insurance activities of tax-exempt organizations

Section 501(m) provides that an organization is not eligible for tax-exempt status under section 501(c)(3) or 501(c)(4) if a substantial part of its activities consists of providing "commercial-type insurance." Commercial-type insurance generally includes any insurance of a type provided by commercial insurance companies, but does not include incidental

health insurance provided by an HMO of a kind customarily provided by an HMO.

6. HMOs as taxable entities

The tax treatment of a taxable HMO (e.g., an HMO organized on a for-profit basis) depends largely on the extent to which it qualifies as an insurance company. In determining taxable income, property and casualty insurance companies include underwriting income. In calculating underwriting income, the company generally may take a reserve deduction for a portion of its unearned premiums and for the discounted amount of losses incurred (including incurred but not reported losses). These deductions may not reflect the "all events" test or the economic performance requirements that generally apply to accrual-method taxpayers.

7. Special rules applicable to certain taxable insurance companies

Section 833 provides special relief for Blue Cross and Blue Shield organizations existing on August 16, 1986, which were exempt from tax for their last taxable year beginning before January 1, 1987, and which have experienced no material change in their structure or operations since August 16, 1986. In addition, section 833 provides special relief for certain other organizations, substantially all of the activities of which involve the provision of health insurance, that meet certain community-service-related requirements.

Section 833 exempts eligible organizations from the rule (referred to above) that is generally applicable to property and casualty insurance companies, requiring a 20-percent reduction in the amount a company can deduct for any increase in unearned premium reserves. In addition, section 833 permits eligible organizations to claim a special deduction with respect to their health business in an amount equal to 25 percent of claims and expenses incurred during the taxable year, less adjusted surplus at the beginning of the year.

Description of Proposal

1. Requirements for tax-exempt health care service organizations

The proposal would impose new requirements on section 501(c)(3) or 501(c)(4) organizations that have as their predominant activity the provision of "health care services."[10] The requirements, therefore,

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[10] The term "health care services" would mean --

(i) any activity for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purposes of affecting any structure or function of the body;

(ii) any activity (such as nursing or old age

generally would apply to tax-exempt hospitals, clinics, nursing homes, old age homes, and HMOs. The proposal would not apply to organizations whose predominant activities are non-health care service activities (e.g., an educational organization, if the predominant activities of the organization do not involve the delivery of health care services to patients). In addition, the proposal specifically would provide that the new requirements do not apply to an organization that demonstrates, consistent with Treasury guidance, that a principal purpose of the organization is academic training or medical research, or to an organization that provides only uncompensated care regardless of the patient's income. The proposal would not apply to State and local governmental entities.

Under the proposal, in addition to satisfying a community benefit standard, tax-exempt organizations described in present-law section 501(c)(3) or 501(c)(4) that have as their predominant activity the provision of health care services would be required to:

(1) provide (directly or indirectly) significant "qualified outreach services." The term "qualified outreach services" would be defined as health care services, or related education or social services programs, provided (a) in an area that is medically underserved with respect to such health care services (such as a health professional shortage area "HPSA" designated by the Secretary of HHS or an area or population group reasonably determined by the organization, consistent with Treasury guidance, to have a shortage of health professionals relative to the number of individuals and their health needs in the area or population group); (b) below cost to individuals otherwise unable to afford such services; or (c) at specialty emergency care facilities that normally operate at a loss (i.e., emergency trauma, emergency psychiatry, or burn centers). An organization would demonstrate that it provides significant qualified outreach services on a facts-and-circumstances basis. An organization would have the option of directly furnishing such services or indirectly providing such services by making a grant or contribution to a donee organization that furnishes qualified outreach services. The provision of insurance would constitute a "qualified outreach service" only if provided on a subsidized basis.

(2) with the participation of community representatives, annually assess the health care and qualified outreach service needs of the community and develop a written plan that sets forth how the organization plans to meet those needs;

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home care) which is part of the exempt purpose of a 501(c)(3) organization solely because it is carried on as part of an activity described in (i) above; and

(iii) insurance (that is not commercial-type insurance under section 501(m)) with respect to an activity described in (i) or (ii) above.

(3) not discriminate in the provision of health care services on the basis of whether an individual is insured by a government-sponsored health plan (e.g., Medicare); and

(4) if the organization provides emergency health care services, not discriminate in the provision of such emergency services on the basis of the patient's ability to pay.

Disclosure requirements.--Organizations would be required to make available to the general public and the IRS the written community health care and outreach service needs plan required in (2) above, in the same manner that the Form 990 is required to be available under present law. In addition, organizations would be required to comply with requests from individuals who seek a copy of such plan (and, if so requested, a copy of the Form 990) by supplying copies without charge other than a reasonable fee for reproduction and mailing costs. (The requirement to provide copies could be waived by the IRS in cases involving abusive, excessive requests for documents). Organizations would be required to disclose information regarding the organization's implementation of the prior year's plan (including unrecovered costs and revenues foregone in furtherance of such plan). An organization also would be required to disclose if it has participated in an improper private inurement transaction that has resulted in the imposition of penalty taxes on a disqualified person or organization manager (see intermediate sanctions described below).

Effective date.--The new statutory requirements for certain tax-exempt health care service organizations would be effective on January 1, 1995.

2. HMO qualification under section 501(c)(3)

Under the proposal, an HMO seeking tax-exempt status under section 501(c)(3) would be required to furnish substantially all of its primary care health services at its own facilities through health care professionals who do not provide substantial health care services other than on behalf of such organization. Thus, tax-exempt status under section 501(c)(3) would be available to an HMO only if it is organized according to a so-called "staff model" or "dedicated-group model." In contrast, an HMO seeking tax-exempt status under section 501(c)(4) would not be required directly to furnish health care services at its own facility (but would, however, be required to meet the requirements of section 501(m), discussed below).

Effective date.--The proposal would be effective on the date of enactment.

3. Tax-exempt status for health insurance purchasing cooperatives and certain parent organizations

Qualified health insurance purchasing cooperatives would be eligible for Federal tax-exempt status, provided that private inurement, lobbying, and political activity restrictions are satisfied (similar to present-law section 501(c)(3)). Health insurance purchasing cooperatives generally

would not be eligible to use financing provided from the proceeds of tax-exempt bonds.

The proposal further would clarify that, under present-law section 509(a), organizations that serve as parent holding companies for hospitals or medical research organizations qualify as public charities rather than private foundations.

Effective date.--These proposals would be effective on the date of enactment.

4. Extend private inurement prohibition to social welfare organizations

The proposal would amend section 501(c)(4) to provide that if a social welfare organization or other organization described in that section has as its predominant activity the provision of health care services, such organization is eligible for tax-exempt status only if no part of its net earnings inures to the benefit of any private shareholder or individual.

Effective date.--The proposal generally would be effective on the date of committee action. However, under a special transition rule, the proposal would not apply to inurement occurring within two years of the date of committee action if such inurement results from a contractual arrangement that was in effect on the date of committee action and is not materially changed before such inurement occurs.

5. Intermediate sanctions for violations of private inurement prohibition

The proposal would impose two-tiered penalty excise taxes as an intermediate sanction in cases where "applicable tax-exempt health care organizations," meaning organizations described in section 501(c)(3) or section 501(c)(4) that have as their predominant activity the providing of health care services (other than private foundations), engage in a transaction resulting in "taxable inurement." These intermediate sanctions could be imposed by the IRS in lieu of revocation of an organization's tax-exempt status. The IRS would have authority to abate the excise tax penalty if the organization establishes that the violation was due to reasonable cause and not due to willful neglect.

"Taxable inurement" would mean any direct or indirect inurement of any part of the net earnings of an organization to the benefit of a disqualified person. Prohibited inurement would result from transactions in which a disqualified person receives unreasonable compensation or engages in a non-fair-market-value transaction with the organization, or from revenue sharing arrangements with a disqualified person that violate the present-law private inurement prohibition. The proposal would clarify that existing tax law standards would apply in determining reasonableness of compensation and fair market value and would identify certain procedural measures that an organization could take to create a presumption of the reasonableness of a compensation arrangement (e.g., approval of the compensation arrangement by an independent board). The proposal also would clarify that payment of personal expenses of, or other benefits granted to,

disqualified persons generally would be treated as compensation only if the organization intended and made the payments as compensation for services (e.g., the payments were included on the W-2 of the disqualified person). The Secretary of Treasury would be instructed to conduct a study of and issue guidance regarding transactions and arrangements that give rise to taxable inurement.

"Disqualified persons" would mean any person who was an organization manager at any time during the five-year period prior to the transaction at issue, as well as certain family members and 35-percent owned entities. The term "organization manager" would mean any officer, director, or trustee of a public charity or social welfare organization (or an individual having powers or responsibilities similar to those of officers, directors, or trustees of the organization), as well as any other individual who is in a position to exercise substantial influence over the affairs of the organization. Any person performing substantial medical services as a physician pursuant to an employment or other contractual relationship with the organization would be treated as an "organization manager."

Beneficiaries of taxable inurement would be subject to a first-tier penalty tax equal to 25 percent of the amount of the taxable inurement (e.g., the amount paid to a disqualified person exceeding reasonable compensation). Organization managers who knowingly participate in taxable inurement would be subject to a first-tier penalty tax of 2.5 percent of the amount of taxable inurement (subject to a maximum amount of tax of $10,000).

Additional, second-tier taxes would apply if "taxable inurement" is not corrected within a specified time period. In such cases, the beneficiary would be subject to a penalty tax equal to 200 percent of the amount of taxable inurement. Organization managers who refused to agree to correction would be subject to a penalty tax equal to 50 percent of the amount of taxable inurement (subject to a maximum amount of tax of $10,000). The term "correction" would mean undoing the inurement to the extent possible, establishing safeguards to prevent future inurement, and where fully undoing the inurement is not possible, such additional corrective action as prescribed by Treasury regulations.

Effective date.--The proposal would apply to inurement occurring on or after the date of committee action.

6. Insurance activities of tax-exempt organizations

Present-law section 501(m) would be clarified to provide that a health maintenance organization shall be treated as not providing commercial-type insurance if and only if: (1) care is provided by the organization to its members at its own facilities through health professionals who do not provide substantial health care services other than on behalf of the organization; (2) care is provided by a health care professional to a member of the organization on a basis under which substantially all of the risk with respect to rates of utilization by the member is assumed by the

health care professional; or (3) if ancillary to care described in (1) or (2), either (a) care other than primary care is provided to a member pursuant to a referral by the HMO, or (b) emergency care is provided to a member at a location outside the member's area of residence.

Effective date.--The proposal would be effective on the date of enactment.

7. Definition of taxable property and casualty insurance companies

The proposal would expand the scope of organizations treated as taxable property and casualty insurance companies. Under the proposal, any organization that is not tax-exempt, is not a life insurance company, and whose primary and predominant business activity during the taxable year falls into one of three categories, would be treated as a property and casualty insurance company. The three categories of activities are: (1) issuing accident and health insurance contracts or reinsuring accident and health risks; (2) operating as an HMO; or (3) entering into arrangements under which fixed payments or premiums are received by the organization as consideration for providing or arranging for the provision of health care services. The proposal would modify the "primary and predominant" requirement in the case of organizations that have, as a material business activity, the issuing or reinsurance of accident and health insurance contracts. For such organizations, the administering of accident and health insurance contracts would be treated as part of such business activity for purposes of determining whether the organization's activities fall within the scope of category (1) above.

Effective date

The proposal would be effective for taxable years beginning after December 31, 1994. A transition rule would provide that, for an organization other than one which (1) treated itself as subject to tax as a property and casualty insurance company on its original Federal tax return for taxable years beginning in 1992 through 1994, or (2) was tax-exempt for its last taxable year beginning before 1995, the change made by the proposal would be treated as a change in method of accounting, and required adjustments would be taken into account for its first taxable year beginning after December 31, 1994. A transition rule for any organization that was tax-exempt for its last taxable year beginning before 1995 and that becomes taxable under the proposal for its first taxable year beginning after December 31, 1994 would provide that, in general, (1) no adjustment would be made under section 481 due to a change in method of accounting required by the proposal for the organization's first taxable year beginning after December 31, 1994, and (2) adjusted basis for determining gain or loss of assets would be equal to fair market value on the first day of its first taxable year beginning after December 31, 1994.

8. Special rules applicable to certain taxable insurance companies

The proposal would repeal the special rules provided under section 833 to Blue Cross and Blue Shield organizations and other eligible

organizations (i.e., the special exception to the 20-percent reduction with respect to unearned premium reserves and the special deduction for 25 percent of claims and expenses).

The proposal would also apply the special rules under section 833 to the same extent they have been provided to certain existing Blue Cross or Blue Shield organizations, in the case of any organization that (1) is not a Blue Cross or Blue Shield organization existing on August 16, 1986, and (2) otherwise meets the requirements of section 833(c)(2) (including the requirement of no material change in operations or structure since August 16, 1986). Under the proposal, an organization qualifies for this treatment only if (1) it is not a health maintenance organization and (2) it is organized under and governed by State laws which are specifically and exclusively applicable to not-for-profit health insurance or health service type organizations.

Effective date.--The proposal generally would be effective for taxable years beginning after December 31, 1996. However, for eligible organizations, the proposal generally would be effective for taxable years beginning after December 31, 1998. Eligible organizations would be those that, for each of the three taxable years beginning before the date of enactment and each taxable year beginning on or after the date of enactment and before December 31, 1998, meet standards for open enrollment, community rating, coverage of pre-existing conditions and related standards.[11]

Transition rules would be provided. For the repeal of the exception to the 20-percent reduction, the proposal would require ratable income inclusion over a 6-year period following the effective date of 20 percent of the unearned premium reserve outstanding at the end of the most recent taxable year beginning before January 1, 1997 (or 1999, for organizations eligible for the December 31, 1998 effective date). For the repeal of the 25 percent of claims deduction, a phase-out would be provided for organizations meeting the community service requirements of present law.

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[11] These standards would be met by an organization if (1) substantially all its activities involve the providing of health insurance or health-related activities, (2) at least 10 percent of the health insurance it provides is provided on a community rated, open enrollment basis to individuals and small groups (taking into account any medicare supplemental coverage), (3) it provides continuous full-year open enrollment (including conversions) for individuals and small groups, (4) its policies covering individuals provide full coverage of pre-existing conditions of high-risk individuals without a price differential (with a reasonable waiting period), and coverage is provided without regard to age, income, or employment status of individuals under age 65, and (5) no part of its net earnings inures to the benefit of any private shareholder or individual. For this purpose, a small group would be the number of individuals required for a small group under applicable State law.

L. MODIFICATION OF RULES FOR CERTAIN QUALIFIED 501(c)(3) BONDS

Present Law

Interest on State and local government bonds generally is excluded from income if the bonds are issued to finance direct activities of these governments (Code sec. 103). Interest on bonds issued by these governments to finance activities of other persons, i.e., private activity bonds, is taxable unless a specific exception is included in the Internal Revenue Code (the "Code"). One such exception is for private activity bonds issued to finance activities of private, charitable organizations described in Code section 501(c)(3) ("section 501(c)(3) organizations") when the activities do not constitute an unrelated trade or business (sec. 141(e)(1)(G)).

Before enactment of the Tax Reform Act of 1986, State and local governments and section 501(c)(3) organizations both were defined as "exempt persons," under the Code bond provisions, and their bonds generally were subject to the same requirements. As exempt persons, section 501(c)(3) organizations (with respect to their exempt activities) were not treated as "private" persons, and their bonds were not "industrial development bonds" or "private loan bonds" (the predecessor designations for most current private activity bonds).

Present law treats section 501(c)(3) organizations as private persons, thus, bonds for their use may only be issued as private activity "qualified 501(c)(3) bonds," subject to the restrictions of Code section 145. The most significant of these restrictions limits the amount of outstanding bonds from which a section 501(c)(3) organization may benefit to $150 million. In applying this $150 million limitation, all section 501(c)(3) organizations under common management or control are treated as a single organization. The limit applies to bonds for all section 501(c)(3) health care facilities except hospital facilities, defined to include only acute care, primarily inpatient, organizations.

Description of Proposal

The proposal would repeal the $150 million per organization limit on outstanding bonds that applies to nonprofit health care facilities that are not acute care, inpatient facilities, and to other section 501(c)(3) organizations. In addition, the proposal would change the tax-exempt bond provisions of the Code to conform generally the treatment of bonds for nonprofit health care and other section 501(c)(3) organizations to that provided for bonds issued to finance direct State or local government activities.

Certain other restrictions, described below, that have been imposed on qualified 501(c)(3) bonds (but not on governmental bonds), and that address specialized policy concerns, would be retained--

(1) The requirement that existing residential rental

property acquired by a section 501(c)(3) organization in a tax-exempt-bond-financed transaction satisfy the same low-income tenant requirements as similar housing financing for for-profit developers;

(2) The present-law maturity limitations applicable to bonds for section 501(c)(3) organizations, and the public approval requirements applicable generally to private activity bonds; and

(3) The penalties on changes in use of tax-exempt-bond-financed section 501(c)(3) organization property to a use not qualified for such financing.

Effective Date

The proposal would apply to bonds issued after December 31, 1994.

M. ELIMINATE EXCLUSION FOR EMPLOYER-PROVIDED ACCIDENT OR HEALTH BENEFITS PROVIDED THROUGH A FLEXIBLE SPENDING ARRANGEMENT

Present Law

1. Cafeteria plans

Under present law, compensation generally is includible in gross income when actually or constructively received, i.e., when it is made available to the individual or the individual has an election to receive such amount. Under one exception to the general principle of constructive receipt, no amount is included in the gross income of a participant in a cafeteria plan maintained by an employer solely because the participant may elect among cash and certain employer-provided qualified benefits. In general, a qualified benefit is a benefit that is excludable from an employee's gross income by reason of a specific provision of the Internal Revenue Code. Employer-provided accident or health coverage is a qualified benefit.

The cafeteria plan exception from the principle of constructive receipt also applies for employment tax purposes.

2. Flexible spending arrangements

A flexible spending arrangement ("FSA") is a reimbursement account or similar arrangement under which an employee is reimbursed for medical expenses or other employer-provided qualified benefits, such as dependent care. FSAs that are part of a cafeteria plan generally are funded through salary reduction. FSAs may also be provided by an employer outside a cafeteria plan. FSAs are commonly used, for example, to reimburse employees for medical expenses not covered by insurance. If certain conditions are satisfied, amounts reimbursed under an FSA are excludable from gross income and wages for employment tax purposes.

Proposed Treasury regulations define a health FSA as a benefit program that provides employees with coverage under which specified, incurred expenses may be reimbursed (subject to reimbursement maximums and any other reasonable conditions) and under which the maximum amount of reimbursement that is reasonably available to a participant for a period of coverage is not substantially in excess of the total premium (including both employee-paid and employer-paid portions of the premium) for such participant's coverage. A maximum amount of reimbursement is not substantially in excess of the total premium if the maximum amount is less than 500 percent of the premium.

Description of Proposal

Under the proposal, accident or health benefits provided under an FSA would be includible in income and wages for income and employment tax purposes. A health FSA would be defined generally as under the proposed Treasury regulations.

Effective Date

The proposal would be effective on and after January 1, 1996.

N. PREMIUM ASSESSMENT

Present Law

There is no excise tax or other special Federal assessment on domestic health insurance policy premiums. A one-percent excise tax is imposed on premiums for certain foreign-issued sickness and accident insurance and reinsurance policies (sec. 4371).

Description of Proposal

1. In general

The proposal would impose an assessment on certain health expenses. Expenses subject to the assessment generally would include the costs of providing health coverage, as well as related administrative expenses and any costs of reinsurance. Health coverage would include, but not be limited to, coverage for sickness, accident, dental, preventive care, or payment of a fixed amount for hospitalization or other specified types of care. To the extent all of these costs are reflected in the premium or other charge to the purchaser of such benefits, the assessment would be imposed on the premium amount. If the costs are reflected in separate charges to the purchaser (i.e., a purchaser buys a health insurance policy and enters into an administrative services contract), the assessment would be imposed on each separate component.

In general, with respect to indemnity health insurance, the assessment would be imposed on premiums. With respect to prepaid health care arrangements, the assessment would be imposed on the fixed payments or

premiums paid by members. With respect to self-insured plans, the assessment would be imposed on the plan's health care expenditures and administrative expenses.

A portion of amounts derived from the imposition of this premium assessment would be used to fund the Academic Health Centers Trust Fund and the Health Research Trust Fund.

2. Assessment on health insurance policy premiums

The proposal would impose a 1.75 percent assessment on certain health insurance policy premiums, effective in 1996. The assessment would be paid by the issuer of the policy and would be imposed regardless of who pays the premium.

The assessment would be imposed on policies providing health care coverage. It would not be imposed on policies if the health care coverage is part of the coverage of liabilities incurred under employees' compensation laws, tort liabilities, or other similar liabilities. If a policy provides both health and other coverage, the assessment would be imposed only on the health portion if the charge for the nonhealth coverage is both separately stated and reasonable in relation to the total policy charges.

Certain prepaid health care arrangements also would be subject to the assessment. Such arrangements would include those pursuant to which an entity receives fixed payments or premiums (that do not vary in amount depending on the amount of health care provided) in exchange for an agreement to provide or arrange for the provision of health care. The entity receiving the payments or premiums would be treated as the issuer of the policy and would pay the assessment.

3. Assessment on health-related administrative services

The proposal would also impose the applicable assessment on amounts paid for certain health-related administrative services not included in the premium for a policy. The assessment would be paid by the provider of the services.

Services subject to the assessment would include claims processing or other administrative services performed in connection with health care coverage (if the charge for such services is not included in the premiums for such policy), and claims processing, arranging for the provision of health care, or other administrative services performed in connection with a self-insured plan established or maintained by another person.

4. Treatment of self-insured plans

Certain self-insured plans would be subject to a monthly assessment equal to the applicable assessment rate times the sum of the plan's health care expenditures and direct administrative expenses. This assessment would be paid by the plan sponsor.

Plans subject to the assessment would be plans that provide health care (other than through an insurance policy) that are established or maintained by one or more (1) employers for the benefit of their current and former employees; (2) employee organizations for the benefit of their current and former members; (3) employers and employee organizations jointly for the benefit of current or former employees; and (4) multiple employer welfare arrangements or plans maintained by rural cooperatives, not described in (1)-(3) above.

5. Exemption applicable to certain governmental programs

Certain direct governmental insurance programs would be exempt from this premium assessment. These would include Medicare, Medicaid, Indian Health Services, and any program that provides health care to members of the Armed Forces or veterans or to their spouses or dependents. Other government programs would be subject to the premium assessment as set forth above.

6. Academic Health Centers Trust Fund, Graduate Medical and Nursing Education Trust Fund, and Health Research Trust Fund

The revenues derived from the premium assessment would fund the Academic Health Centers Trust Fund, the Graduate Medical and Nursing Education Trust Fund, and the Health Research Trust Fund established under the proposal.

Effective Date

The proposal would be effective after December 31, 1995.

O. TAX TREATMENT OF FUNDING OF RETIREE HEALTH BENEFITS

Present Law

Under present law, employer-provided post-retirement medical benefits are generally excludable from the gross income of a plan participant or beneficiary. In addition, an employer may deduct contributions, within limits, made to a welfare benefit fund for retiree health and life insurance benefits of its employees. A welfare benefit fund is, in general, any fund that is part of a plan of an employer, and through which the employer provides welfare benefits to employees or their beneficiaries.

Contributions by an employer to a welfare benefit fund are not deductible under the usual income tax rules, but, if they otherwise would be deductible under the usual rules (e.g., if they are ordinary and necessary business expenses), the contributions are deductible within limits for the taxable year in which such contributions are made to the fund.

The amount of the deduction otherwise allowable to an employer for a contribution to a welfare benefit fund for any taxable year may not exceed

the qualified cost of the fund for the year. The qualified cost of a welfare benefit fund for a year is the sum of (1) the qualified direct cost of the fund for the year and (2) the addition (within limits) to the qualified asset account under the fund for the year, reduced by (3) the after-tax income of the fund.

A qualified asset account under a welfare benefit fund is an account consisting of assets set aside to provide for the payment of disability payments, medical benefits, supplemental unemployment compensation benefits or severance pay benefits, or life insurance benefits. Under present law, an account limit is provided for the amount in a qualified asset account for any year.

The account limit for any taxable year may include a reserve to provide certain post-retirement medical and life insurance benefits. This limit allows amounts reasonably necessary to accumulate reserves under a welfare benefit plan so that the liabilities for post-retirement medical and life insurance benefits with respect to a group of employees can be prefunded over the working lives of such employees.

Under present law, if an employer maintains a welfare benefit fund that provides a disqualified benefit during any taxable year, the employer is subject to an excise tax equal to 100 percent of the disqualified benefit. A disqualified benefit includes (1) a benefit provided to a key employee other than from a separate account required to be established for such an employee, (2) any post-retirement medical or life insurance benefit that is provided in a discriminatory manner, and (3) any portion of a welfare benefit fund reverting to the employer.

Description of Proposal

Under the proposal, the minimum period during which the cost of post-retirement medical and life insurance coverage could be funded under a welfare benefit fund would be at least 10 years. Thus, an employer would be permitted to deduct the costs of funding such coverage on a level basis over the working lives of covered employees, but not over a period of less than 10 years.

The proposal would clarify that a reserve to provide post-retirement medical and life insurance benefits under a welfare benefit plan would be maintained as a separate account. In addition, the proposal would include any payment from the separate account required to be maintained for post-retirement medical and life insurance benefits that is not used to provide a post-retirement medical or life insurance benefit in the list of disqualified benefits for which the employer is subject to a 100-percent excise tax.

Effective Dates

The proposal relating to reserves for post-retirement medical and life insurance benefits under welfare benefit plans would be effective for contributions paid or accrued after December 31, 1994, in taxable years

ending after that date. The proposal that would require that the reserve for post-retirement medical and life insurance benefits be maintained as a separate account would be effective for contributions paid or accrued after the date of enactment, in taxable years ending after that date.

P. NONREFUNDABLE CREDIT FOR CERTAIN PRIMARY HEALTH SERVICES PROVIDERS

Present Law

1. Geographically targeted tax provisions

In general, the operation of Internal Revenue Code rules does not vary based on the location within the United States of income-producing activity. Nonetheless, present law provides favorable Federal income tax treatment for certain U.S. corporations that operate in Puerto Rico, the U.S. Virgin Islands, or possessions of the United States to encourage the conduct of trades or business within these areas. In addition, certain Code sections provide additional benefits in targeted geographic areas (e.g., low-income housing credit and qualified mortgage bond provisions target certain economically distressed areas).

The Omnibus Budget Reconciliation Act of 1993 ("1993 Act") provides for the designation of nine empowerment zones and 95 enterprise communities in economically distressed areas satisfying certain criteria. The designations are to be made during 1994 and 1995, and generally will remain in effect for 10 years. During the period the designation is in effect, special tax incentives (i.e., an employer wage credit, additional section 179 expensing, and expanded tax-exempt financing) are available for certain business activities conducted in empowerment zones. Expanded tax-exempt financing benefits are available for certain facilities located in enterprise communities. In addition, the 1993 Act provides accelerated depreciation benefits and an incremental employer wage credit for certain business activities conducted on Indian reservations.

2. Tax benefits available for medical care providers

Code section 108(f) provides an exclusion from Federal income tax for what otherwise would be discharge-of-indebtedness income if a student loan is discharged pursuant to a provision in the loan agreement that requires the student to work for a period of time in certain professions for any of a broad class of employers. Section 108(f) applies only to student loans made from funds provided by the Federal Government, a State or local government, or certain public benefit corporations described in section 501(c)(3). For example, the favorable treatment provided by section 108(f) applies when a government agency discharges a student loan upon the student's provision of medical services to an underserved area.

Present law does not provide for a special credit against Federal income taxes for individuals who provide medical services in medically underserved geographic areas.

3. Nontax benefits for medical care providers

Other, non-tax provisions of Federal law provide that certain health care professionals who agree to work full time for at least two years at an approved government or nonprofit employment site within a "health professional shortage area" (HPSA) are eligible for scholarships or repayments of student loans.[12] The scholarship and loan repayment programs are administered by the National Health Service Corp (NHSC), which is part of the Department of Health and Human Services.[13]

Description of Proposal

A physician who provides primary health services in certain medically underserved areas would be eligible for a nonrefundable credit against Federal income taxes of $1,000 per month for up to 36 months ($500 per month if the physician already was providing medical services in an underserved area at the time the credit becomes effective). The credit rate would be $500 per month in the case of a physician assistant, nurse-practitioner, or certified nurse-midwife (regardless of when the individual began providing medical services in an underserved area). The credit would be available to a taxpayer only if he or she provides primary

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[12] HPSAs are designated geographic areas, as well as certain designated population groups and government facilities. Currently, more than 2,400 primary care HPSAs have been designated, covering all or parts of 1,800 counties in the United States. There are also over 1000 dental HPSAs and over 700 mental health HPSAs. HPSAs are designated by the Bureau of Primary Health Care, which is part of the United States Public Health Service. HPSAs are identified on the basis of State and local government requests for designation. Primary care HPSAs are designated on the basis of rate of poverty, access to primary health care, low birthweight births, infant mortality, and the physician/population ratio. See vol. 59 Federal Register no. 14 (January 21, 1994) at 3411-5307. The NHSC Revitalization Amendments of 1990 (sec. 333A of Pub. Law 101-697) require that the Secretary of HHS annually prepare a list of HPSAs in order of greatest shortage of medical practitioners (by using certain exclusive factors) and that priority in the assignment of National Health Service Corp (NHSC) personnel be given to government or nonprofit entities serving HPSAs with the greatest shortages. See 42 U.S.C. 254f-1.

[13] As of September 30, 1993, a total of 1,163 practitioners (i.e., primary-care physicians and physician assistants, general practice dentists, primary-care nurse practitioners, and certified nurse midwives) were providing medical care in HPSAs throughout the United States pursuant to the NHSC scholarship and loan repayment programs.

health services[14] on a full-time basis in a "health professional shortage area" (HPSA) (as defined under present-law section 332(a)(1)(A) of the Public Health Service Act).[15] To be eligible for the credit, the taxpayer would be required to obtain certification from the Bureau of Primary Health Care, United States Public Health Service of the Department of Health and Human Services, that he or she is a full-time provider of primary health services in a HPSA, and, in the case of a taxpayer working in an urban HPSA, that he or she performs services (as an employee or independent contractor) for a governmental or nonprofit entity.[16] The credit would not be available, however, if the taxpayer participated in the National Health Service Corps (NHSC) scholarship or loan repayment program.

Under the proposal, a taxpayer would be required to work full time providing primary health services in the HPSA for two consecutive years (following certification) in order to receive the tax credit. If a taxpayer did not provide primary health services on a full-time basis in the HPSA for at least two consecutive years (following certification), any credit previously claimed would be completely recaptured. The Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, would be granted authority to waive recapture of credits when a taxpayer ceases to provide services in the HPSA due to extraordinary circumstances.

Effective Date

The proposal would be effective for taxable years beginning after 1994.

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[14] For purposes of the provision, the term "primary health services" would have the meaning given such term by section 330(b)(1) of the Public Health Service Act.

[15] See Title 42, U.S. Code, sections 254e and 254f-1. For purposes of the proposal, medically underserved areas would include population groups and public facilities that have HPSA designation.

[16] For purposes of the credit, a health care practitioner would be treated as providing services in a HPSA, even if the area no longer has designation as such, so long as the area was designated as a HPSA when the practitioner was certified by the Department of HHS as being eligible for the credit (i.e., the practitioner was already working in an area designated as a HPSA at the time the credit became effective or subsequently began practicing in an area when it was designated as a HPSA).

Q. EXPENSING OF MEDICAL EQUIPMENT USED IN HEALTH CARE SHORTAGE AREAS

Present Law

1. Depreciation rules

In general, the cost of property that has a useful life longer than one year must be capitalized and recovered over time pursuant to depreciation or amortization rules. Tangible depreciable property placed in service after 1986 is depreciated under the modified Accelerated Cost Recovery System (MACRS) enacted as part of the Tax Reform Act of 1986. Under MACRS, high technology medical equipment is depreciated for regular tax purposes over a 5-year recovery period using the 200-percent declining balance method. "High technology medical equipment" means any electronic, electromechanical, or computer-based high technology equipment used in the screening, monitoring, observation, diagnosis, or treatment of patients in a laboratory, medical, or hospital environment.

In general, MACRS deductions are reduced for property under an alternative depreciation system by calculating depreciation using the straight-line method over the property's class life. A property's class life generally corresponds to its Asset Depreciation Range (ADR) midpoint life and often is longer than the recovery period applicable for regular tax purposes. The alternative depreciation system applies to foreign use property, tax-exempt use property, tax-exempt bond financed property, certain imported property, and property which the taxpayer so elects and is used to compute corporate earnings and profits. The class lives of the alternative depreciation system also are used for purposes of the corporate and individual alternative minimum tax. The class lives of some assets are set by statute, regardless of the asset's ADR midpoint life. The class life of high technology medical equipment is set by statute at five years.

2. Section 179 expensing allowances

In lieu of depreciation, a taxpayer with a sufficiently small amount of annual investment may elect to deduct up to $17,500 of the cost of qualifying property placed in service for the taxable year under section 179.[17] In general, qualifying property is defined as depreciable tangible personal property that is purchased for use in the active conduct of a trade or business. The $17,500 amount is reduced (but not below zero) by

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[17] Section 13116 of the Omnibus Budget Reconciliation Act of 1993 increased the amount allowed to be expensed under section 179 from $10,000 to $17,500 for qualified property placed in service in taxable years beginning after 1992. In addition, under section 13301 of the 1993 Act, the amount allowed to be expensed under section 179 by an enterprise zone business is increased by the lesser of: (1) $20,000 or (2) the cost of section 179 property that is qualified zone property placed in service during the taxable year.

the amount by which the cost of qualifying property placed in service during the taxable year exceeds $200,000. In addition, the amount eligible to be expensed for a taxable year may not exceed the taxable income of the taxpayer for the year that is derived from the active conduct of a trade or business (determined without regard to this provision). Any amount that is not allowed as a deduction because of the taxable income limitation may be carried forward to succeeding taxable years (subject to similar limitations).

Description of Proposal

The proposal would increase the amount allowed to be expensed under section 179 in a taxable year by the lesser of: (1) the cost of section 179 property which is health care property placed in service during the year or (2) $15,000. For this purpose, "health care property" would mean section 179 property: (1) which is medical equipment used in the screening, monitoring, observation, diagnosis, or treatment of patients in a laboratory, medical, or hospital environment; (2) which is owned (directly or indirectly) and used by a physician (as defined by section 1861(r) of the Social Security Act) in the active conduct of such physician's full-time trade or business of providing primary health services (as defined in section 330(b)(1) of the Public Health Service Act) in a health professional shortage area ("HPSA") (as defined in section 332(a)(1)(A) of the Public Health Service Act); and (3) substantially all the use of which is in such area. Similar to the proposed nonrefundable credit for certain primary care providers, physicians working in urban HPSAs would be eligible for the additional section 179 expensing only if they perform services for a government or nonprofit entity.

Effective Date

The proposal would apply to property placed in service in taxable years beginning after December 31, 1994.

R. COORDINATION WITH HEALTH CARE CONTINUATION PROVISIONS

Present Law

In general, an employer with 20 or more employees must provide health plan participants with the opportunity to continue their coverage in the employer's health plan for a specified period of time after the occurrence of certain qualifying events that otherwise would have terminated such coverage.

The qualifying events that may trigger rights to continuation coverage are (1) the death of the employee, (2) the voluntary or involuntary termination of the employee's employment (other than by reason of gross misconduct), (3) a reduction of the employee's hours, (4) the divorce or legal separation of the employee, (5) the employee becoming entitled to benefits under Medicare, (6) a dependent child of the employee ceasing to be a dependent under the employer's plan, and (7) in certain cases the

commencement of bankruptcy proceedings with respect to an employer. The maximum period of health care continuation coverage that may be elected is 36 months, except in the case of termination of employment or reduction of hours for which the maximum period is 18 months. The 18-month period is extended to 29 months in certain cases involving the disability of the plan participant. Certain events, such as the failure by the plan participant to pay the required premium, may trigger an earlier cessation of the health care continuation coverage.

Within limits, employers may require health plan participants that elect health care continuation coverage to pay for such coverage.

Description of Proposal

The proposal would retain the present-law health care continuation rules, except that the maximum period of continuation coverage that could be elected by a qualified beneficiary for any qualifying event would be reduced. Under the proposal, a qualified beneficiary could elect health care continuation coverage for the longer of 6 months or until the end of the calendar year in which the qualifying event occurs.

Effective Date

The proposal would be effective with respect to qualifying events that occur on or after January 1, 1997.

S. DISCLOSURE OF TAXPAYER RETURN INFORMATION FOR ADMINISTRATION OF HEALTH SUBSIDY PROGRAMS

Present Law

The Internal Revenue Code prohibits disclosure of tax returns and return information, except to the extent specifically authorized by the Code (sec. 6103). Unauthorized disclosure is a felony punishable by a fine not exceeding $5,000 or imprisonment of not more than five years, or both (sec. 7213). An action for civil damages also may be brought for unauthorized disclosure (sec. 7431). No tax information may be furnished by the Internal Revenue Service (IRS) to another agency unless the other agency has established procedures satisfactory to the IRS for safeguarding the tax information it receives (sec. 6103(p)).

Description of Proposal

The proposal would permit disclosure of certain taxpayer return information to any Federal, State, or local agency administering health subsidy programs for use in verifying eligibility for such subsidies. Disclosable information would include taxpayer return information relating to adjusted gross income, the untaxed portion of social security benefits,

and tax-exempt interest income.[18] In addition, information regarding marital status and dependents could be disclosed.

Taxpayer return information would only be disclosed in response to a taxpayer's application for a health subsidy, only to the agency responsible for determining eligibility for the subsidy,[19] and only to the extent necessary to make that determination.

Under the proposal, any Federal, State, or local agency receiving taxpayer return information would be required to comply with the safeguards presently contained in the Code governing the use of disclosed tax information. Also, the present-law penalties for unauthorized disclosure of information would apply to recipient agencies and their employees.

Effective Date

The proposal would be effective on the date of enactment.

T. TAX TREATMENT OF VOLUNTARY EMPLOYER HEALTH CARE CONTRIBUTIONS

Present Law

There is currently no requirement that employers contribute to health plans on behalf of their employees. If an employer elects to contribute towards the cost of a health plan on behalf of its employees, the employer generally may determine the level of contributions it will make to the plan. Employers can generally deduct the full cost of employer-provided health care as an ordinary and necessary business expense.

Employer-provided health coverage is generally fully excludable from gross income. However, if an employer provides its employees with health benefits under a self-insured medical reimbursement plan (sec. 105(h)), reimbursements under such plan are excludable with respect to a highly compensated individual only to the extent that the plan does not discriminate in favor of highly compensated individuals either as to eligibility to participate or as to benefits. Under the requirements for nondiscrimination in benefits, a self-insured plan may establish a limit for the amount of reimbursement which may be paid for any single benefit or

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[18] In addition, welfare benefits would be considered to be income for purposes of computing eligibility for a health subsidy. Welfare benefits are not income for tax purposes and are not presently reported to the IRS. They are therefore not return information for purposes of the tax disclosure rules. A separate reporting system for welfare benefits would be established under the proposal.

[19] Disclosure would also be permitted for reviewing and auditing health subsidy determinations.

combination of benefits under the plan. However, any maximum limit on the amount of reimbursement for health expenses attributable to employer contributions under a self-insured medical expense plan must be uniform for all participants and for all dependents of employees who are participants and may not be modified by reason of a participant's age or years of service (Treas. Reg. § 1.105-11(c)(3)(i)).

Description of Proposal

1. In general

The proposal would not require employers to contribute toward the cost of health coverage for any employee. However, employers that voluntarily contribute toward the cost of health coverage for their employees would be required to satisfy certain voluntary contribution rules. Employers that violate the voluntary contribution rules would be subject to an excise tax designed to approximate the effect of denying the employer deduction for health expenses.

2. Limitation on deductibility of employer contributions for health coverage other than permitted coverage

Under the proposal, employer contributions to an accident or health plan other than employer contributions for permitted coverage would be subject to an excise tax designed to approximate the effect of denying the employer deduction for such health expenses. Permitted coverage would include (1) coverage under a certified standard health plan, (2) cost-sharing amounts under a certified standard health plan (including cost-sharing policies), (3) coverage providing wages or payments in lieu of wages for any period during which the employee is absent from work on account of sickness or injury, (4) coverage providing payment for permanent injuries of an employee, his or her spouse or a dependent that are computed with reference to the nature of the injury without regard to the period the employee is absent from work (but not coverage under a long-term care insurance policy), (5) coverage provided to an employee or former employee after such employee has attained age 65 unless such coverage is provided by reason of the current employment of the individual with the employer providing the coverage, (6) coverage provided under Federal law to veterans or any member of the Armed Forces of the United States and their spouses and dependents and (7) coverage under a certified supplemental health plan, and (8) coverage under a certified long-term care insurance policy.

The provision does not affect the present-law rules regarding taxation of employer contributions for coverage or the taxation of any payments received by the individual. Whether or not something is permitted coverage for purposes of the excise tax is independent of income or employment tax treatment.

The excise tax would not be imposed with respect to any period for which it is established to the satisfaction of the Secretary that the employer did not know nor, through exercising reasonable diligence, should have known, that coverage did not meet the applicable standards.

3. Voluntary employer contributions cannot vary based on health status

Any employer that voluntarily contributes towards the cost of coverage for employees under a health plan cannot impose a waiting period, deny coverage, or vary the amount of the contribution based on any employee's health status, claims experience, medical history, receipt of health care, or lack of evidence of insurability.

4. Same voluntary employer contribution

Any employer that voluntarily contributes towards the cost of coverage for any employee under a certified standard health plan would be required to contribute either the same dollar amount or the same percentage (with or without a dollar cap) towards the cost of the standard coverage selected by any other employee. This rule would be applied separately with respect to full-time employees and part-time employees. Employers that voluntarily contribute to the purchase of any part-time employee's coverage would be required to make a contribution to all part-time employees proportionate to the number of hours worked by the part-time employee. The voluntary contribution requirement would apply only to coverage under a certified standard health plan made available by the employer (consistent with other parts of the proposal).

For example, assume that an employer offers to pay 80 percent of a $4,000 premium for single coverage under a certified health maintenance organization for all of its full-time salaried employees, but not for any of its part-time employees. Under the proposal, the employer would be required to offer to contribute one of the following amounts towards the cost of single or family coverage for all full-time employees: (1) the same dollar amount ($3,200), (2) the same percentage (80 percent) of the single or family premium, or (3) the same percentage (80 percent) of the single or family premium, but no more than $3,200. No contribution would be required with respect to part-time employees.

A full-time employee would be an employee who is normally employed at least 24 hours in a week. A part-time employee would be an employee who is normally employed at least 10 hours per week and less than 24 hours per week. The following employees (whether full-time or part-time) would be excluded for purposes of this rule: (1) employees who have not completed 6 months of service; (2) employees who normally work not more than 6 months during any year; (3) employees who are included in a unit of employees covered by a collective bargaining agreement if health coverage was the subject of good faith bargaining; (4) employees who have not attained age 18; and (5) employees who are non-resident aliens and who receive no U.S. source earned income.

For purposes of the proposal, certain aggregation rules would apply. All employees of corporations that are members of a controlled group of corporations, or all employees of trades and businesses (whether or not incorporated) that are under common control, would be aggregated and treated as if employed by a single employer (sec. 414(b) and (c)). Similarly, all employees of employers that are members of an affiliated

service group would be treated as employed by a single employer (sec. 414(m)). Finally, the Secretary of the Treasury would have general regulatory authority to prevent avoidance of the voluntary contribution requirements through the use of certain arrangements (sec. 414(o)). Under the proposal, if an employer is treated as operating separate lines of business for a year for pension plan purposes, the employer may apply the voluntary contribution rules separately to each separate line of business for that year.

5. Penalties for employer violations of the voluntary contribution rules

Employers that violate either of the voluntary contribution rules would be subject to an excise tax designed to approximate the effect of denying the employer deduction for health expenses. If an employer impermissibly varies health care contributions based on health status or violates the rules relating to contributions for health coverage other than permitted coverage, the excise tax would be equal to the product of the highest corporate income tax rate in effect (currently 35 percent) and the total health care expenses for coverage other than permitted coverage incurred by the employer during the period in which the violation occurs. If an employer violates the rules relating to employer contribution levels, the excise tax would be equal to the product of the highest corporate income tax rate in effect (currently 35 percent) and the total health care expenses for standard coverage incurred by the employer during the period in which the violation occurs.

Both excise taxes would be imposed on all employers that violate the voluntary contribution requirements, including tax-exempt and governmental employers. The excise taxes would not be deductible. The Secretary of the Treasury would be permitted to waive all or part of both excise taxes under certain circumstances, to the extent that the payment of such taxes would be excessive relative to the failure involved.

Effective Date

The voluntary contribution rules would apply to employer contributions made on or after January 1, 1996.

U. ASSESSMENT ON LARGE EMPLOYERS

Present Law

No provision.

Description of Proposal

Under the proposal, an annual assessment of 1 percent of payroll would be imposed on employers with 500 or more employees. Payroll would mean the sum of (1) wages (as defined for hospital insurance tax purposes under the proposal); (2) in the case of a sole proprietorship, the net earnings from

self employment of the proprietor attributable to the trade or business; (3) in the case of a partnership, the aggregate of the net earnings from self employment of each partner which is attributable to the partnership; and (4) in the case of an S corporation the aggregate of the net earnings from self employment of each shareholder which is attributable to such corporation. Net earnings from self employment would be defined as under the proposal.

Effective Date

The proposal would be effective on and after January 1, 1996.

V. INCREASE EXCISE TAX ON HANDGUN AMMUNITION

Present Law

1. Ad valorem excise taxes

A 10-percent excise tax is imposed on the sale of pistols and revolvers by a manufacturer, producer or importer thereof. Other firearms and shells and cartridges are subject to an 11-percent excise tax (Code sec. 4181).

An exemption is provided for sales of firearms and ammunition for use by the United States Department of Defense. In addition, no excise tax is imposed on sales by manufacturers, producers or importers: (1) for use by the purchaser in further manufacture, or for resale by the purchaser for use by the second purchaser in further manufacture; (2) for export, or for resale by the purchaser to a second purchaser for export; (3) for use by the purchaser as supplies for military vessels or aircraft; (4) to a State or local government for their exclusive use; or (5) to a nonprofit educational organization for its exclusive use. In general, the effect of the State and local government exemption is to exempt sales to State and local police departments.

Amounts equivalent to revenues from these excise taxes fund the Federal Aid to Wildlife Program for use in making grants to support State wildlife programs.

2. Transfer and making taxes; special occupational taxes

a. Transfer and making taxes.--Present law also imposes making and transfer taxes on certain firearms and other destructive devices. A transfer tax of $200 is imposed on each "firearm" transferred, and a making tax at the rate of $200 is imposed on each firearm made (Code secs. 5811 and 5821). The ad valorem excise taxes described above do not apply to firearms subject to these making and transfer taxes.

Firearms subject to the making and transfer taxes are machine guns, short-length or short-barrelled rifles or shotguns, pen guns, handguns with smooth bore barrels, firearms silencers, mufflers or suppressors, silencer

parts, machine gun receivers and parts designed to convert a weapon into a machine gun (generally, firearms subject to regulation under the National Firearms Act ("NFA firearms")).

In general, Federal, State and local governments are exempt from the making and transfer taxes. In addition, transfers between persons subject to the special occupational tax (described below) are exempt from the transfer tax, as are transfers of unserviceable firearms and exported firearms.

b. Special occupational tax.--All importers, manufacturers and dealers in NFA firearms are required to register with the Secretary of the Treasury. Importers and manufacturers are subject to a special occupational tax of $1,000 per year (small importers and manufacturers are eligible for a reduced rate of tax); dealers are subject to a special occupational tax of $500 per year (Code sec. 5801).

An exemption from the special occupational tax is available for persons who conduct business exclusively with or on behalf of the United States.

Description of Proposal

The proposal would increase the ad valorem excise tax rate on certain handgun ammunition. Centerfire cartridges with a cartridge case of less than 1.3 inches in length and cartridge cases of less than 1.3 inches in length would be taxed at 50 percent. A 10,000-percent rate would apply to (1) jacketed, hollow point projectiles which may be used in a handgun and are designed to produce, upon impact, evenly-spaced sharp or barb-like projections that extend beyond the diameter of the unfired projectile; and (2) cartridges with a projectile measuring 0.500 inch or greater in diameter which may be used in a handgun. The taxation of rifle ammunition and .22 caliber rimfire cartridges generally would not be affected by the proposal.

Amounts equivalent to revenues from these increased excise taxes would be added to the General Fund and would not be used to fund the Federal Aid to Wildlife Program.

The proposal also would impose a special occupational tax on each importer and manufacturer of handgun ammunition (i.e., centerfire cartridges with a cartridge case of less than 1.3 inches in length and cartridge cases of less than 1.3 inches in length) of $10,000 per year. These importers and manufacturers also would be required to register with the Secretary of Treasury.

Effective Date

The proposal generally would be effective after December 31, 1994. A floor stocks tax would be imposed on taxed ammunition products held for sale on January 1, 1995.

W. PREFUNDING OF POSTAL SERVICE RETIREE HEALTH BENEFITS

Effective February 1, 1995, the U. S. Postal Service would be required to prefund health benefits for retirees.

VIII. MEDICAID

Present Law

Title XIX of the Social Security Act (Medicaid) provides for mandatory coverage by all States of acute care services for individuals and families receiving either Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI) income support payments. These groups are referred to as the "cash population" within Medicaid. In addition, States must extend coverage to pregnant women and children up to age six with family incomes up to 133 percent of the Federal poverty level and children born after September 1983 up to 100 percent of the Federal poverty level. The Medicaid program provides States the option to extend coverage of pregnant women and children up to age one up to 185 percent of poverty. There are many other optional and mandatory coverage groups for acute care Medicaid services, one of which is Medically Needy eligibility under which families with significant medical care expenses can 'spend down' into Medicaid eligibility.

Federal law establishes a basic set of mandatory services that States must provide including: inpatient and outpatient hospital services; laboratory and x-ray services; rural health clinic and federally qualified health center services; nursing facility services; family planning services; early and periodic screening, diagnostic and treatment (EPSDT) services for children under 21 years old; home health services; and physician, nurse midwife and certain certified nurse practitioner services. There are many other services a State may choose to offer including: prescription drugs, case management, personal attendant care, physical therapy, rehabilitation, and mental health services.

Description of Proposal

A. ACUTE CARE SERVICES

1. AFDC and Acute Care Non-Cash Population

Both groups would be integrated into the general health care reform program and these groups would be treated like other low-income people eligible for Federal subsidies and enrollment in certified health plans. States would be required to make general maintenance of effort (MOE) payments for services covered under the standard benefit package. The State MOE would be indexed to new Federal premium targets. The Federal government would subsidize the health coverage purchase of this group in the same manner as other low-income individuals.

2. Disabled Medicaid Population

SSI/Medicaid beneficiaries would not be included in the community rated market. States would have the option to pay a per capita amount for each SSI/Medicaid recipient (who is not enrolled in Medicare) to certified health plans. States would negotiate with certified health plans for rates

for the Medicaid disabled population that are separate from the community rate. No certified health plan could have more than 50 percent of its enrollment composed of SSI/Medicaid recipients.

3. Individuals Dually Eligible for Medicaid and Medicare

This group would remain under Medicaid and would not be enrolled in health plans.

Effective Date

January 1, 1997.

B. SUPPLEMENTAL SERVICES

Current Medicaid rules governing covered services and recipient eligibility would be retained to cover services not otherwise provided through certified health plans. Because Medicaid is a secondary payer when a recipient has private coverage, the program would provide supplemental services for low-income groups currently entitled to Medicaid. The current flexibility provided to States to determine the optional services and groups it will cover would be retained.

Effective Date

January 1, 1997.

C. DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

The Federal share of these matching payments would be gradually phased down over a period of years, beginning Fiscal Year 1997. The DSH program would be changed into a more targeted program to compensate hospitals for uncompensated care.

D. MEDICAID LONG TERM CARE

The Medicaid program would be amended to:

1. Increase the Federal Medical Assistance Percentage by 10 percentage points for: personal care attendant services, Sec. 1915 home and community based long term care waiver services, and the frail elderly home care option under Medicaid.

2. Allow States to expand eligibility for home-based Medicaid long term care services for single individuals by increasing the asset limit from $2,000 to $4,000 for services including personal care attendant services, the Sec. 1915 waiver programs, and the frail elderly home care option.

3. Expand the Program of All-inclusive Care for the Elderly. Increase authorized demonstration sites from 15 to 40. Require the

Secretary of HHS to develop provider and service protocols.

4. Eliminate the requirement that individuals need to have been institutionalized as a condition of eligibility for habilitation services under a home and community based care waiver.

5. Eliminate the 'cold bed rule' for waiver programs that currently requires States to demonstrate the availability of an institutional bed in order to have an equivalent slot in a home and community based waiver program.

E. MISCELLANEOUS MEDICAID PROVISION

State Medicaid programs would be required to reimburse directly for services provided by all certified nurse practitioners or clinical nurse specialists that they are legally authorized under State law or regulation to perform, whether or not they operate under the supervision of a physician or other health care provider.

IX. LONG TERM CARE AND SUPPLEMENTAL INSURANCE STANDARDS

A. LONG TERM CARE INSURANCE STANDARDS

Present Law

No provision.

Description of Proposal

1. Definition of Long Term Care Policies

Policies covered under this Part include any insurance policy, rider or certificate that is advertised, marketed, offered or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity prepaid or other basis for one or more diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care hospital. Policies not covered under this Part include policies designed to provide basic Medicare supplemental coverage, basic hospital expense coverage, basic medical-surgical expense coverage, disability income or related asset protection coverage, accident-only coverage, specified disease coverage or limited health benefit coverage. Policies that accelerate death benefits and that provide the option of lump sum payments are not covered in this Part.

2. Regulatory Oversight

a. Participating States would be required to certify policies as meeting new Federal standards. An insurer selling a policy not certified by the State would be subject to a civil monetary penalty not to exceed 50 percent of gross premiums received from sale of the policy. States would be permitted to develop stricter standards as long as no State provision is inconsistent with Federal standards.

b. The Secretary of HHS, in consultation with the National Association of Insurance Commissioners (NAIC), would be required to develop model standards incorporating the requirements of this Part within one year of enactment.

c. Participating States would be required to develop a long term care insurance standard regulatory and enforcement program, which includes adoption of the NAIC model act standards, a process for individuals to file complaints about violations of the standards, consumer access to those complaints, and a premium review and approval process.

3. Marketing Requirements

a. Insurers or agents would be prohibited from knowingly making any misleading representation, or incomplete or fraudulent comparison, of any

long term care insurance policy. They would be prohibited from using any force, fright, threat, or undue pressure, whether implicit or explicit. They also would be prohibited from employing any marketing method that fails to be explicit that the purpose of the marketing is solicitation of insurance.

b. The Secretary of HHS in consultation with the NAIC would be required to develop minimum financial standards for the purpose of advising potential purchasers as to the costs and amounts of coverage needed.

c. Insurers and agents would be prohibited from knowingly selling a long term care insurance policy to an individual who is eligible for Medicaid.

d. Insurers and agents could not knowingly sell policies that duplicate coverage already held by the potential purchaser unless the purchaser provides written documentation that the new coverage did not duplicate the coverage already held or that the new policy would replace existing coverage.

e. Any agent who sells, or offers for sale, a policy in violation of the marketing and sales standards would be subject to a civil monetary penalty not to exceed $15,000 for each violation. An insurer or carrier that offers for sale a policy in violation of these requirements would be subject to a civil monetary penalty not to exceed $25,000 for each violation.

f. The Secretary in consultation with the NAIC would be required to establish standards for the training of agents who sell long term care policies and specify procedures for the certification of agents who have completed such training.

4. Requirements Relating to Coverage Under a Policy

a. If an application for coverage is denied by an insurer, the insurer would be required to return directly to the applicant any premiums paid within 30 days of the date of denial.

b. If an application for coverage is accepted, the insurer shall provide the insurance policy and an outline of coverage within 30 days of coverage approval.

c. If a claim for coverage under a policy is denied, the insurer would be required to notify the policyholder in writing within 15 days of the reason(s) for the denial of coverage. The insurer shall make available all records related to the denial and inform the policyholder how to appeal the denial.

5. Reporting Requirements

Insurers would be required to report annually, to the State Insurance Commissioner, information including the number and type of long term care

policies in effect and the associated premiums, the rate of premium increase for these policies, the lapse rates and replacement rates for these policies, and the number of claims denied.

6. Agent Compensation

Agent commissions from the sale of a long term care policy to a first-time holder of the policy would be limited to no more than 200 percent of the commission paid for renewing the policy in the second year. Agent commissions, if based on a percent of premium costs, could not exceed 50 percent of the first year premium. Agent commissions or compensation would be required to be level for policy renewals over the next 5 years.

7. Rules for Issue, Renewals and Cancellations

a. A long term care policy could only be canceled due to nonpayment of premiums, or material misrepresentation or fraud on the part of the policyholder.

b. Each group long term care insurance policy would be required to provide covered individuals with the option for continuation or conversion from a group to an individual policy that meets certain criteria. Conversions from a group policy would be required meet certain premium pricing requirements.

c. Insurers and agents would be required to guarantee the issue of a policy if the individual meets the minimum medical underwriting guidelines.

d. The Secretary in consultation with the NAIC would be required to develop standards concerning policy rating and pricing of policy benefit upgrades.

e. The Secretary in consultation with the NAIC would be required to develop standards concerning policy rate stabilization.

f. A long term care policy must allow for reinstatement of a policy canceled due to non-payment of premium if the policyholder is determined to be cognitively incapacitated and the policyholder acts to reinstate (with full payment of back premiums) within five months.

8. Use of Standardized Definitions and Terminology

The Secretary of HHS, in consultation with the NAIC, would be required to develop standard definitions and terminology, and standard policy description formats for use in all long term care policies.

9. Benefits Standards

a. Benefits would not be permitted to be conditioned on the need for, or receipt of, any other service, nor on the medical necessity for the benefit, nor on services furnished by providers or facilities meeting conditions beyond those required by State licensure or certification.

b. If home health benefits are covered under a policy, the policy would not be permitted to restrict these services to those provided by registered nurses or licensed practical nurses, nor to services provided by Medicare certified agencies. Services would be required to include those of a home health aide or other home care employee under certain conditions, and would be required to provide personal care, respite, and certain other basic community-based services.

c. If nursing facility benefits are covered under a policy, the policy would not be permitted to restrict the type of nursing facility covered.

d. A per diem policy could not condition benefit payments on the receipt of specific services nor on the receipt of services from specific types of providers.

e. A long term care policy would not be permitted to treat covered benefits for individuals with Alzheimer's disease, other progressive degenerative dementia, mental illness, or mental retardation differently from benefits for individuals with a functional impairment.

f. An insurer would be permitted to exclude or condition benefits based on a medical condition for which the policyholder received treatment or was otherwise diagnosed within 6 months before the issuance of the policy. The policy would be permitted to exclude coverage of that pre-existing condition for up to 6 months from the start of coverage under the policy.

g. An insurer could not deny coverage due to a pre-existing condition if the application for coverage did not request such information with resepct to such condition.

10. Functional Assessments and Appeals Process

Functional assessments would be conducted by individuals or organizations not under the control of the insurer. Each insurer would provide for an independent process, meeting certain standards, for appeal of functional assessments and claims denials.

11. Inflation Protection

Long term care policies would be required to include inflation protection meeting minimum Federal standards unless the insurer obtains from the policyholder a written rejection of this coverage.

12. Non-Forfeiture

Long term care policies would be required to include mandatory non-forfeiture benefits in a form to be established by the Secretary, in consultation with the NAIC.

Effective Date

States would be required to implement enforcement programs by April 1, 1997. States without such a program would be subject to a loss of Federal Medicaid matching payments for long term care services.

B. STANDARDS FOR SUPPLEMENTAL INSURANCE

1. Definition of Supplemental Health Benefits Policies

Present Law

Health plans that supplement private health benefits purchased by employers and individuals are not subject to Federal standards. Policies that supplement Medicare benefits are subject to Federal regulation under Section 1882 of the Social Security Act.

Description of Proposal

Supplemental health benefits policies would be defined to include two types of policies: (a) supplemental services policies, and (b) cost-sharing policies. Supplemental services policies would include: (a) coverage for services and items not offered in the certified standard health plan, and (b) coverage for items in the certified standard health plan, but not covered because of limitation in amount, duration or scope. Cost-sharing policies would include those that provide coverage for out-of-pocket payments, including co-insurance, deductibles and copayments.

In order to be certified, health plans or insurers offering a supplemental health benefits policy would be required to meet Federal standards. States, or in the case of multistate self-insured plans the Secretary of Labor, would be required to certify that the supplemental health benefits policies meet the Federal standards. A health plan or insurer offering a supplemental health benefits plan in violation of Federal standards would be subject to civil penalties not to exceed 50 percent of gross premiums from the provision of policies in violation of the standards.

The following types of policies would not be defined as supplemental health benefits policies and would not be covered by Federal standards regarding supplemental health benefits policies: (a) insurance that provides benefits only with respect to specific diseases; (b) hospital or nursing home indemnity policies; (c) Medicare supplemental insurance policies; (d) insurance with respect to accidents; (e) coverage only for disability income; (f) coverage issued as a supplement to liability insurance; and (g) employees' compensation or similar insurance. Long term care insurance policies are not included in the definition of supplemental health insurance plans and are regulated elsewhere in this Part.

2. Standards for Supplemental Service Policies

Health plans or insurers offering policies that supplement services in the certified standard health plan would be required to meet the following

Federal standards: (a) guaranteed issue, with one annual open enrollment period of at least 30 days, except in cases where supplemental service policies are offered to employees by their employer or to individuals based on their membership in a fraternal, religious, professional, educational or other similar organization; (b) guaranteed renewal, except for nonpayment of premiums, fraud, or misrepresentation of a material fact; and (c) community rating, with rates modified by community-rating area, family size and age, as in certified standard health plans. Health plans or insurers would not be permitted to deny coverage or vary premiums for eligible persons based on health status, medical condition, claims experience, receipt of health care, or medical necessity.

Health plans or insurers would be prohibited from offering: (a) a supplemental health benefits policy that duplicates coverage provided in the standardized benefit package of a certified standard health plan; and (b) a supplemental health benefits policy that duplicates coverage provided under Medicare to a Medicare eligible individual.

Not later than January 1, 1996, the Secretary would be required to develop minimum standards that prohibit marketing practices by health plans or insurers offering supplemental services policies that involve: (a) tying or otherwise conditioning the sale of a supplemental services policy to the sale of a certified standard health plan sold by the same company; (b) using or disclosing any information about the health status or claims experience of participants in a certified standard health plan; or (c) prohibiting managed care plans which provide the certified standard health plan from offering a supplemental services policy to a person not enrolled in the managed care plan.

3. Standards for Cost-Sharing Policies

Persons are only permitted to obtain a cost-sharing policy from the same certified standard health plan in which they are enrolled. Health plans would only be permitted to offer cost-sharing policies to persons enrolled in their certified standard health plan. Nothing would require a person to obtain a cost-sharing policy and nothing would require a health plan to provide one.

Certified standard health plans offering cost-sharing policies would be required to offer them to all individuals enrolled in their certified standard health plan. Cost-sharing policies would be offered during the same open enrollment period established for certified standard health plans and supplemental services policies. Certified standard health plans would be required to provide coverage for items and services in the cost-sharing health plan to the same extent as provided in the certified standard health plan. Certified standard health plans would be required to offer a cost-sharing policy at the same price to all individuals (community rating). The price at which the cost-sharing policy is offered would be required to take into account any increase in utilization for items and services in the certified standard health plan.

4. Prohibiting Offer of Multiple Plans to Individuals

Health plans or insurers would be prohibited from offering a supplemental health benefits policy to an individual covered under another supplemental plan of the same type, unless the individual's coverage under the new policy begins after the old coverage is terminated.

Effective Date

January 1, 1997.

X. MEDICARE

A. INDIVIDUAL ELECTION TO REMAIN IN PRIVATE HEALTH PLANS

Present Law

Under current law, individuals who become eligible for Medicare cannot choose to remain in a private managed care plan unless that plan has a risk or cost contract with Medicare.

Description of Proposal

The proposed change would require health maintenance organizations that have or would be eligible for a Medicare risk contract under Section 1876 of the Social Security Act to offer continued membership in the health plan (with the same benefits) to enrollees who become eligible for Medicare and their spouse and dependents. Payment would be made to such health plans on the same basis as Medicare payments to risk contracting organizations. Individuals electing this option would be charged a premium by the health plan equal to the difference between the health plan's premium (adjusted to reflect the actuarial difference between the Medicare beneficiaries and other plan enrollees) and the Medicare payment amount. Payments would begin in the first month an individual is eligible for Medicare and would cease in the open enrollment month specified by the Secretary, or the month in which the individual ceases to be eligible for Medicare. Payments under this section would be the sole Medicare payment to which the beneficiary is entitled.

B. PROVISIONS RELATED TO PART A

1. Payment Updates for Prospective Payment System (PPS) for Inpatient Hospital Services

Present Law

Under the prospective payment system, there are different standardized base payment amounts for hospitals located in large urban areas (metropolitan statistical areas with a population over 1 million or 970,000 in New England), other urban areas, and rural areas. Different update factors apply to the urban and rural base payment amounts. Medicare dependent and sole community hospitals are paid based on the higher of the applicable standardized amount or a hospital-specific rate updated annually. The update factors are based on the projected increase in the hospital market basket, an index that measures changes in the prices of goods and services purchased by hospitals. The update factors are as follows:

(a) Fiscal year 1995: For urban hospitals, the estimated percentage increase in the hospital market basket minus 2.5 percentage points; for rural hospitals, the amount necessary to equalize the

rural and "other urban" standardized amounts. The update factors for the hospital-specific rates applicable to a sole community hospital or a Medicare-dependent, small rural hospital are set equal to the percentage increase in the hospital market basket minus 2.2 percentage points.

(b) Fiscal year 1996: For all hospitals, the percentage increase in the hospital market basket minus 2.0 percentage points.

(c) Fiscal year 1997: For all hospitals, the percentage increase in the hospital market basket minus 0.5 percentage point.

(d) For fiscal years 1998 and thereafter, the update factor for all hospitals is set equal to the percentage increase in the hospital market basket.

Description of Proposal

For fiscal years 1997 through 2000, the update factor for all hospitals (urban, rural, sole community, and Medicare-dependent) would be set equal to the percentage increase in the hospital market basket minus 2.0 percentage points.

Effective Date

Upon enactment.

2. Reduction in Payments for Capital-Related Costs for Inpatient Hospital Services

Present Law

Medicare pays hospitals for inpatient capital expenses under a prospective payment system. During a ten-year transition that began in fiscal year 1992, hospitals are paid based on a blend of Federal rates and hospital-specific capital rates. The initial Federal rate was computed based on unaudited 1989 cost-report data, trended forward to 1992. The hospital-specific rates were based on data from each hospital's 1990 cost report, trended forward to 1992. The Federal and hospital-specific rates are updated annually for inflation.

The Omnibus Budget Reconciliation Act of 1993 reduced the Federal capital rate by 7.4 percent to correct errors in the inflation forecasts used to establish the Federal rates.

Hospitals excluded from the prospective payment system (psychiatric, rehabilitation, children's, cancer, and long-term hospitals and psychiatric and rehabilitation distinct part units) are paid on a reasonable cost basis for the capital-related costs of inpatient services.

Description of Proposal

Adjustments would be made to the Federal and hospital-specific capital payment rates. For discharges occurring after September 30, 1995 the Secretary would reduce by 7.31 percent the unadjusted standard Federal capital rate in effect as of the date of enactment, and would reduce by 10.4 percent the unadjusted hospital specific rate in effect on that date.

Payment for capital-related costs for hospitals excluded from the PPS payment system would be reduced by 15 percent.

Effective Date

Effective for hospital discharges occurring on or after October 1, 1995.

3. Reductions in Payment Adjustments for Disproportionate Share Hospitals

Present Law

Under the prospective payment system, Medicare provides additional payments to hospitals serving a disproportionate share of low income patients. The adjustment amount is determined using formulas based on the disproportionate share patient percentage. The disproportionate share patient percentage is defined as the sum of the percentage of total patient days that are attributed to non-Medicare-eligible Medicaid beneficiaries and the percentage of Medicare patient days that are attributed to Medicare beneficiaries that are also eligible for Supplemental Security Income benefits. Separate formulas are provided for various categories of urban and rural hospitals.

Description of Proposal

The Secretary would be required to reduce payments that would otherwise be made under the disproportionate share adjustment by 25 percent.

Effective Date

Effective for hospital discharges occurring on or after October 1, 1997.

4. Changes in Payment Methodology for PPS-Excluded Hospitals

Present Law

Hospitals excluded from the prospective payment system (psychiatric, rehabilitation, children's, cancer, and long-term hospitals and psychiatric and rehabilitation distinct part units) are paid on a reasonable cost basis subject to a rate of increase limit on operating costs per discharge. The per discharge limit, or target amount, is updated annually.

Description of Proposal

Rehabilitation hospitals and distinct part units would be assigned their 1990 and 1991 Medicare cost reporting periods as a new base year. Limits for subsequent periods would be determined based on per-discharge Medicare operating cost averaged over the two year period. The rebasing would:

(a) Hold harmless those hospitals and units under their limits by paying them their costs plus incentive payments;

(b) Provide a floor of 70 percent of the national average for each type of facility for those facilities with very low limits; and

(c) Provide a ceiling of 110 percent of the national average for each type of facility for new facilities.

The Secretary would be required to complete development of a prospective payment system for rehabilitation hospitals and distinct part units, including a patient classification system, and present recommendations to Congress by October 1, 1996.

Conditions for exclusion of rehabilitation hospitals and distinct part units from the PPS would be expanded to account for the impact of new technologies and survival rates and the changes in the practice of rehabilitation medicine over the past decade.

Any long term hospital meeting a two year financial loss test and a low-income patient load test, would be assigned an average of their 1990 and 1991 Medicare cost reporting periods as a new base year. In any subsequent two year period in which both tests were met, the Secretary would be required to assign the hospital a new base year averaging the costs of the two years. A hospital meets the financial loss test if it has had two consecutive years of losses where its costs exceed its limit. A hospital satisfies the low-income patient load test if it has a Medicare disproportionate share patient percentage of greater than 25 percent.

Effective Date

October 1, 1994.

5. Extension of Freeze on Updates to Routine Service Costs of Skilled Nursing Facilities

Present Law

Medicare payment for skilled nursing facility services is made on a reasonable cost basis subject to a limit on routine costs per diem. The limit is based on 112 percent of the mean per diem routine service costs for freestanding facilities. There is an add-on to the limit for hospital-based facilities equal to 50 percent of the difference between 112 percent of the mean per diem routine costs for freestanding facilities and 112 percent of the mean per diem routine costs for hospital-based facilities. OBRA 1993 prohibited the Secretary from applying an update factor to the cost limits for skilled nursing facility cost reporting periods beginning in fiscal years 1994 and 1995.

Description of Proposal

The Secretary would be required to limit to 100 percent the upper limit on payment for reasonable routine service costs for services in skilled nursing facilities.

Effective Date

October 1, 1995.

6. Payments for Sole Community Hospitals with Teaching Programs and Multi-Hospital Campuses

Present Law

The Secretary is required to determine diagnosis-related group (DRG) specific rates for hospitals in different areas. Requirements to reimburse multi-campus facilities based on the location of the discharge applies only to hospitals not exempt from PPS and to hospitals reimbursed on the basis of DRGs and not to hospitals reimbursed on a cost basis.

Description of Proposal

The Secretary would establish separate rates of payment for each facility of a sole community hospital with multi-hospital campuses when at least one of the hospitals of the multi-hospital campus is eligible to receive indirect medical education payments.

Effective Date

October 1, 1993 for hospitals that merged after October 1, 1987.

7. Medicare Dependent Hospitals

Present Law

To qualify for Medicare Dependent Hospital (MDH) status, a hospital must be located in a rural area, have no more than 100 beds, and have at least 60 percent of its inpatient days or discharges attributed to Medicare patients during the cost reporting period beginning during fiscal year 1987. MDHs are eligible for payment under the same rules as sole community hospitals for cost reporting periods beginning on or after April 1, 1990 and ending before April 1, 1993. For discharges occurring during any cost reporting period beginning on or after April 1, 1993, through September 30, 1994, an MDH would receive 50 percent of the difference between its payment under the MDH rules and the payment regularly provided under the prospective payment system.

Description of Proposal

The proposal would clarify that payment amounts are determined by using a 36 month cost reporting period. The target amount definitions needed to make the calculations for MDHs would be extended to September 30, 1998.

MDHs would receive 50 percent of the difference between their payment under the MDH rules and the payment regularly provided under the prospective payment system through September 30, 1998.

Effective Date

Effective beginning with hospital discharges occurring on or after October 1, 1994.

8. Rural Health Transition Grants

Present Law

OBRA 87 instituted grant programs to assist rural hospitals with fewer than 100 beds in developing and implementing projects to modify the type and extent of services they provide. Grants may be used to develop health systems with other providers, diversify services, recruit physicians, improve management systems, and provide instruction and consultation via telecommunications to physicians in health professional shortage areas. The program was authorized at $25 million per year for fiscal years 1990 through 1992.

Description of Proposal

Appropriations for the rural health transition grant program would be

authorized at $30 million per year for fiscal years 1993 through 1999. Rural primary care hospitals would be eligible for grants.

Effective Date

Upon enactment.

9. Limited Service Hospitals, Essential Access Community Hospitals and Medical Assistance Facilities

Present Law

Under the Essential Access Community Hospitals/Rural Primary Care Hospital (EACH/RPCH) program, up to 7 States may be designated by the Secretary to receive grants to develop rural health networks consisting of EACHs and RPCHs.

The Medical Assistance Facility (MAF) program currently operates a demonstration project that exempts small rural hospitals from certain licensure laws, expands the role of mid-level practitioners and improves Medicare payment.

There is no provision for limited service hospital programs or for rural emergency medical services programs.

Description of Proposal

The Secretary would be required to establish a limited hospital service program to coordinate rural hospital payment methodologies and delivery systems, including MAF, EACH/RPCH, and rural emergency medical services.

The MAF demonstration program would be made permanent, and all States would be permitted to participate. Funding of $5,000,000 per year for MAF would be authorized for fiscal years 1996 through 1999.

The Essential Access Community Hospital (EACH)/Rural Primary Care Hospital program (RPCH) would be extended to all States and authorized for $15,000,000 per year for fiscal year 1990 through fiscal year 1998. The requirement that RPCH hospitals not have a length of stay exceeding 72 hours would be changed to allow an average length of stay not exceeding 96 hours. The requirement that hospitals be designated as EACHs would be discontinued. RPCHs, however, would be required to establish linkages with other providers. The requirement that the Secretary develop a prospective payment system for RPCHs would be repealed. Instead, RPCHs would be reimbursed using the MAF reimbursement methodology, including costs of contracts for services with other providers. Hospitals currently certified as EACHs would be permitted to retain Sole Community Hospital status.

A rural emergency medical services program would be established to

improve emergency medical services (EMS) operating in rural and frontier communities. Funding of $5,000,000 per year for fiscal years 1996 through 1999 would be authorized to provide grants to States to coordinate EMS programs.

Effective Date

Effective for hospital discharges on or after October 1, 1994.

C. PROVISIONS RELATED TO PART B

1. Updates for Physicians' Services

Present Law

Under current law, payments for some services covered under Part B are updated each year by an inflation index. Prior to 1984, physician fees were updated annually by the Medicare Economic Index (MEI). The MEI measures inflation in the cost of providing physician services. From 1984 through 1991, the MEI update was often set in reconciliation legislation. The MEI is currently estimated to be 2.2 percent for 1995.

Beginning in 1992, Medicare physician fees are updated annually by a default formula, unless Congress acts. This update is based on two things: (1) the MEI; and (2) a comparison of actual physician spending in a base period compared to an expenditure goal known as the Medicare Volume Performance Standard (MVPS). Separate goals are set for surgical, primary care, and non-surgical services (excluding primary care).

If the MVPS was exceeded in the base period, the update for services within the category is equal to the MEI reduced by the percentage by which the target was exceeded. If expenditures were less than the MVPS, the update is the MEI increased by the percentage by which expenditures in the category were below the target.

The Omnibus Budget Reconciliation Act of 1993 (OBRA 93) reduced the default updates for 1994 by 3.6 percentage points for surgical services, and 2.6 percentage points for all other services (including anesthesia services), except for primary care, which received the full default update. The 1994 updates are 10.0 percentage points for surgical services, 5.3 percentage points for non-surgical service (including anesthesia services), except for primary care services, which received a 7.9 percent update.

OBRA 93 also reduced the default updates for 1995. The default update is reduced by 2.7 percentage points for surgical services and all other services (including anesthesia services), except primary care services, which receive the full update.

Under the default formula, the Secretary of HHS has estimated that the 1995 updates will be as follows: 13.2 percentage points for surgical services; 6.7 percentage points for non-surgical services (excluding

primary care services); and 9.4 percentage points for primary care services.

Description of Proposal

The proposed change would reduce the 1995 default update by 4.0 percentage points for surgical services, 4.0 percentage points for non-surgical services, and 1.0 percentage point for primary care services.

Effective Date

Upon enactment.

2. Substitution of Real Gross Domestic Product (GDP) for Volume and Intensity in the Volume Performance Standard

Present Law

The Omnibus Budget Reconciliation Act of 1989 (OBRA 89) established a system of Medicare volume performance standards (MVPS) which is used to calculate the annual update in fees (conversion factor) for physician and certain other Part B services after January 1, 1992. Under this system, Congress would enact a specific level of increase in expenditures for a subsequent calendar year. In the absence of Congressional action, the rate of increase in expenditures is determined by a formula set in law. The MVPS is based on an estimate of: (1) the percentage increase in Medicare fees; (2) the increase in the number of Part B enrollees, excluding enrollees in HMO risk-contracts; (3) an estimate of the historical rate of increase in the volume and intensity of services delivered; and (4) any change in payment due to legislation or regulation. This is reduced by a performance standard factor, which equals 3.5 percentage points in 1994 and 4.0 percentage points in each subsequent year.

Under current law, there is a lower limit on the default updates to the physician fee schedule. The annual update to the fee schedule can be no lower than the MEI minus 3.0 percentage points in calendar 1994 and minus 5.0 percentage points in 1995 and succeeding years.

Description of Proposal

The proposed change would specify that the historical rate of increase in the volume and intensity of services delivered would be deleted from the MVPS. Substituted in its place would be the average per capita growth in real (inflation-adjusted) GDP for the 5 year-period beginning with the previous fiscal year (1994). The performance standard factor would be repealed. In addition, the lower limit on the default update would be repealed.

Effective Date

Upon enactment.

3. Payments for Physician Services Relating to Inpatient Stays in Certain Hospitals

Present Law

There generally are no adjustments to amounts payable to physicians when covered services are provided to inpatients of hospitals. Each physician submits claims for services rendered, and the amounts paid are determined in accordance with the Medicare physician fee schedule. The only exceptions to this general rule are when physicians provide services as part of a surgical team or when they supervise services provided by certified registered nurse anesthetists.

Description of Proposal

The Secretary would be directed to develop for all hospitals paid under the prospective payment system, annual, hospital-specific case-mix adjusted relative value units per admission and determine whether a hospital exceeds the allowable average per admission relative value units applicable to the medical staff for the year. If the Secretary determines that the rate for the hospital exceeds the allowable average per admission, the Secretary would reduce payments for physician services to hospital inpatients. By October 1 of each year, the Secretary would notify each hospital of its specific relative values.

In the case of urban hospitals, the allowable average per admission relative value units would be equal to 125 percent for admissions in 1998 and 1999, and 120 percent thereafter of the median 1996 hospital-specific relative value units per admission for all hospital medical staffs.

In the case of rural hospitals for each year beginning with 1998, the allowable per admission relative value units would be equal to 140 percent of the median 1996 hospital-specific relative value units per admission for all hospital medical staffs.

The hospital specific projected relative value units for a hospital would be equal to the average relative value units per admission for physician services furnished to inpatients during 1996 by the hospital's medical staff and billed to Medicare, adjusted for variations in case mix, the disproportionate share adjustment, and indirect teaching adjustment, if applicable.

The projected excess relative value units for a year would mean the number of percentage points (as determined by the Secretary) by which a medical staff's hospital specific per admission relative value units exceed the allowable average per admission relative value units.

The amount of payments otherwise due would be reduced by 15 percent for each service furnished for hospitals whose relative value units per admission exceed the allowable average per admission.

Not later than October 1 each year, beginning in 1999, the Secretary

would be required to determine each hospital's actual average per admission relative value units using claims forms submitted not later than 90 days after the last day of the previous year, adjusted for case mix, and the disproportionate share and indirect teaching adjustments.

In cases in which a hospital's actual average per admission relative value units were reduced and were also below the allowable average rate, the Secretary would reimburse the hospital medical staff's fiduciary agent the amount that was withheld plus accrued interest. In cases where the actual average relative value units were less than 15 percentage points above the allowable average, the Secretary would reimburse the hospital medical staff's fiduciary agent an amount equal to the difference between 15 percentage points and the actual number of percentage points by which the staff exceeded the allowable average per admission relative value units plus accrued interest.

Hospital medical executive committees would be given a one-year advance notice of projected excessive relative values and would designate a fiduciary agent to receive and disburse amounts withheld by the Secretary that are subsequently returned. Alternatively, the Secretary could distribute such amounts directly to physicians who treated patients in the hospital on a pro-rata basis based on the proportion of services provided by each physician during the year.

Effective Date

Effective for services furnished on or after January 1, 1998.

4. Incentives for Physicians to Provide Primary Care

Present Law

Physicians providing services in health professional shortage areas, as defined in Sec. 332 of the Public Health Services Act, currently receive a bonus equal to 10 percent of the Medicare payment amount for each physician service delivered.

Description of Proposal

The proposed change would increase the bonus payment for primary care services, as defined in Sec. 1842(i)(a) of the Social Security Act, to 20 percent for each physician service. The bonus payment for other physician services (excluding primary care) would be set at 10 percent for services delivered in health professional shortage areas located in rural areas. The 10 percent bonus payment for non-primary care services delivered in health professional shortage areas located in urban areas would be eliminated.

Effective Date

Upon enactment.

5. Development and Implementation of Resource-Based Methodology for Practice Expenses

Present Law

From 1992 to 1996, Medicare is phasing in a fee schedule with separate components for physician work, practice expense and malpractice expense. Practice expense includes office rents, employees wages, physician compensation, and physician fringe benefits. Payment for the physician work component of the fee schedule is based on a resource-based relative value scale (RBRVS), but payment for practice expense and malpractice expense are based on historical charges.

Description of Proposal

The Secretary would be required to develop a methodology for implementing in 1997 a resource-based system for determining practice expense relative value units for each physician service. In developing the methodology, the Secretary would consider the staff, equipment and supplies used in the provision of various medical and surgical services in various settings. The Secretary would be required to report to Congress on the methodology by January 1, 1996. The existing payment methodology would be repealed when the new payment methodology takes effect in 1997.

Effective Date

Upon enactment.

6. Elimination of Formula-Driven Overpayment for Certain Hospital Outpatient Services

Present Law

The aggregate amount of Medicare payments made for hospital outpatient services (or rural primary care hospital services) furnished in connection with ambulatory surgery, radiology and diagnostic tests equals the lesser of: (1) the lower of a hospital's reasonable costs or its customary charges, net of deductible or co-insurance amounts, and (2) a blended amount comprised of a cost portion and a charge portion. The cost portion of the blend is based on the lower of a hospital's costs or charges net of beneficiary cost-sharing. The cost portion of the blend is 42 percent for ambulatory surgery and radiology services and 50 percent for diagnostic tests. The charge portion of the blend is 58 percent of the ambulatory surgery center (ASC) payment rates net of beneficiary co-insurance, and 58 percent of the physician fee schedule amount for radiology services net of co-insurance, and 50 percent of the physician fee schedule for diagnostic tests net of co-insurance.

A hospital may bill a beneficiary for co-insurance equal to twenty percent of its charge for an outpatient service. However, the blended amounts are calculated after application of beneficiary cost sharing (e.g. lower of hospital cost or charges net of cost sharing and 80 percent of the

ASC rate). This inconsistency in application of cost-sharing results in an anomaly whereby the amount a beneficiary pays in co-insurance does not result in a dollar for dollar decrease in Medicare program payment.

Description of Proposal

Using the current blend percentages, the payment formula would be changed to determine the blended payment limit prior to the application of beneficiary cost-sharing provisions. Medicare's payment amount would be determined based on the lesser of (1) the lower of the hospital's reasonable costs or customary charges, or (2) the blended payment limit. Medicare would then pay the lesser of (1) 80 percent of the lowest amount, or (2) the lowest amount less the beneficiary cost-sharing amounts.

Effective Date

Effective for services furnished during portions of cost-reporting periods occurring on or after January 1, 1995.

7. Payments to Eye and to Eye and Ear Specialty Hospitals

Present Law

Hospitals designated as eye, or as eye and ear hospitals receive a blended payment rate for ambulatory surgery for which 75 percent is based on the hospital's costs and 25 percent is based on the rate paid to freestanding ASCs. In general, the blended payment rate to hospitals for outpatient surgery is based 42 percent on costs and 58 percent on the ASC rate. This rule applies for cost reporting periods beginning on or after October 1, 1988, and before January 1, 1995.

Description of Proposal

The use of the 75/25 blend for eye hospitals, and eye and ear hospitals would be extended to services provided until September 30, 1997.

Effective Date

January 1, 1995.

8. Imposition of Co-insurance for Laboratory Services

Present Law

Medicare beneficiaries are required to make co-insurance payments equal to 20 percent of Medicare's approved payment amount for certain services. Since 1987, payment of co-insurance has not been required for clinical laboratory services.

Description of Proposal

The proposed change would require Medicare beneficiaries to pay co-insurance equal to 20 percent of the approved Medicare payment amount for clinical laboratory services.

Effective Date

January 1, 1995.

9. Application of Competitive Acquisition Process for Part B Items and Services

Present Law

Medicare pays for computer axial tomography (CT) scans and magnetic resonance imaging (MRI) tests on the basis of the Medicare physician fee schedule. The fee schedule has two parts: a technical component for performing the test and a professional component for interpreting the test. Either part of the test can be billed separately.

Payments for oxygen and oxygen equipment are made on the basis of a fee schedule for durable medical equipment.

Description of Proposal

The proposed change would direct the Secretary to establish competitive acquisition areas for procurement of CT scans, MRI tests and oxygen and oxygen equipment.

The Secretary would be permitted to establish different competitive acquisition areas for different items and services. The competitive acquisition areas would be required to be, or be within, metropolitan statistical areas (MSAs). They would be chosen by the Secretary based on the availability and accessibility of suppliers and the probable savings to be realized from the use of competitive bidding.

The Secretary would be required to conduct a competition among individuals and entities supplying items and services for each competitive acquisition area. The Secretary would only be permitted to award a contract if the individual or entity meets quality standards specified by the Secretary.

A competitive acquisition contract would specify: (1) the quantity of items and services to be provided; and (2) other terms and conditions specified by the Secretary.

If competitive acquisition failed to result in at least a 10 percent reduction in the payment amount for these services, the Secretary would be required to make reductions in payment levels for these services to achieve a 10 percent reduction.

Effective Date

January 1, 1995.

10. Application of Competitive Acquisition Process for Clinical Laboratory Services

Present Law

Medicare payments for clinical laboratory services are made on the basis of local fees in payment areas designated by the Secretary. Each fee schedule payment is limited by a national cap. The cap is set at 84 percent of the median of all fee schedule payments for a particular test in 1994, 80 percent in 1995, and 76 percent in 1996 and thereafter.

Description of Proposal

The proposed change would direct the Secretary to establish competitive acquisition areas for procurement of clinical laboratory services.

The Secretary would be permitted to establish different competitive acquisition areas for different items and services. The competitive acquisition areas would be required to be, or be within, metropolitan statistical areas (MSAs). They would be chosen by the Secretary based on the availability and accessibility of suppliers and the probable savings to be realized from the use of competitive bidding.

The Secretary would be required to conduct a competition among individuals and entities supplying items and services for each competitive acquisition area. The Secretary would only be permitted to award a contract if the individual or entity meets quality standards specified by the Secretary.

A competitive acquisition contract would specify: (1) the quantity of items and services to be provided; and (2) other terms and conditions specified by the Secretary.

If competitive acquisition failed to result in at least a 10 percent reduction in the payment amount for laboratory services, the Secretary would be required to make reductions in payment levels for these services to achieve a 10 percent reduction.

Effective Date

January 1, 1995.

11. Part B Premium

Present Law

From 1984 through 1990, the Part B premium was set to cover 25 percent of Part B spending for aged beneficiaries. The remaining 75 percent was funded from general revenues. The Omnibus Budget Reconciliation Act of

1990 established the monthly Part B premium in statute through 1995 to cover 25 percent of Part B spending as follows: $29.90 in 1991, $31.80 in 1992, $36.60 in 1993, $41.10 in 1994 and $46.10 in 1995. The Omnibus Budget Reconciliation Act of 1993 extended the 25 percent Part B premium policy through 1998, but did not specify actual premiums in law.

Description of Proposal

The proposed change would permanently set Part B premiums at 25 percent of Part B spending for aged beneficiaries.

Effective Date

Upon enactment.

D. PROVISIONS RELATED TO MEDICARE PARTS A AND B

1. Medicare Secondary Payer

Present Law

(a) Extension of Transfer of Data

OBRA 89 authorized the establishment of a database to identify working beneficiaries and their spouses to improve identification of cases in which Medicare is secondary to third-party payers. The data match links Internal Revenue Service (IRS) tax records with data from the Health Care Financing Administration (HCFA). The Omnibus Budget Reconciliation Act of 1993 authorized an extension of the transfer of data through September 30, 1998.

(b) Extension of Medicare Secondary Payer for Disabled Beneficiaries

Medicare is the secondary payer to certain group health plans offered by employers of 100 or more employees for disabled beneficiaries. The authority for this provision expires September 30, 1998.

(c) Extension of 18-Month Rule for ESRD Beneficiaries

Medicare is the secondary payer to certain employer group health plans covering beneficiaries with end stage renal disease (ESRD) during the first 18 months of a beneficiary's entitlement to Medicare on the basis of ESRD. The authority for this provision expires September 30, 1998.

Description of Proposal

(a) Extension of Transfer of Data

The authority for the transfer of data would be made permanent.

(b) Extension of Medicare Secondary Payer for Disabled Beneficiaries

The Medicare secondary payer requirements for disabled beneficiaries

would be made permanent.

(c) Extension of 18-Month Rule for ESRD Beneficiaries

The Medicare secondary payer requirements for beneficiaries with end stage renal disease would be made permanent.

Effective Date

Upon enactment.

2. Expand Centers of Excellence

Present Law

Medicare currently has two demonstration projects that involve competitive contracts with "centers of excellence" to perform coronary artery bypass graft surgery and cataract surgery for one payment that includes all services provided in connection with these procedures. The bypass surgery demonstration is currently being conducted in seven cities and the cataract surgery demonstration is being conducted in three cities.

Description of Proposal

The proposed change would direct the Secretary to expand the demonstration projects for coronary artery bypass and cataract surgery in urban areas. Payment would be made on the basis of a negotiated or all-inclusive rate, beginning with fiscal year 1995.

The amount of payment would be required to be less than the aggregate amounts of payments the Secretary would have made if the demonstrations were not conducted. Payment for coronary artery bypass surgery would include the bypass procedure and related services.

The Secretary would be required to make a payment to each beneficiary to whom services are provided under this demonstration equal to 10 percent of the difference between what the Secretary would have paid for these services in the absence of this provision and what the Secretary actually paid for the services under this provision.

Effective Date

Upon enactment.

3. Medicare Select

Present Law

The Omnibus Budget Reconciliation Act of 1990 (OBRA 90) requires that all Medigap policies conform to one of ten standard benefit packages, including a core benefit package that must be made available by all Medigap insurers, and nine other packages that an insurer has the option of

offering. In general, Medigap policies may not be canceled and must be guaranteed renewable as long as premiums are paid. OBRA 90 also permitted the offering of a new Medicare supplement policy, known as Medicare Select, in 15 States. The only difference between standard Medigap and Medicare Select is that Select policies will only pay full benefits if covered services are obtained through selected health professionals.

Description of Proposal

The proposed change would permit Medicare Select policies to be offered in all States. The three year limitation would be eliminated. A health maintenance organization could offer a Medicare supplemental policy that does not conform to at least one of the ten standard benefit packages if: (1) the benefits include at least the core benefits package, although the plan could charge nominal copayments, and (2) the benefit package including any copayments, when combined with Medicare benefits, is substantially similar to benefits provided to non-Medicare enrollees of the health maintenance organization. A Medicare Select policy may be canceled or not renewed in the case of an individual who leaves the service area of the policy, except that if the individual moves to an area for which the issuer of the Medicare Select policy (or an affiliate) offers a Medigap policy, the alternative must be made available to the individual.

Effective Date

The National Association of Insurance Commissioners (NAIC) would have nine months after the date of enactment to revise the current model regulations to reflect this provision and to make other changes of a technical nature. If the NAIC does not revise its model regulations within the stated time frame, the Secretary would be required to develop a regulation and would have 9 months to do so.

The revised model regulations or Federal regulations would apply in each State on the date the State adopts such regulations or one year after the regulations are developed, whichever is earlier. Special provisions are included for States whose legislatures will not meet during the one year period following the development of the regulations.

4. Medicare Supplemental Insurance Polices (Medigap)

Present Law

Medical underwriting and certain other practices are prohibited with respect to Medicare supplemental policies for which an individual age 65 or older applies during the six-month period beginning with the first month which an individual is first enrolled for benefits under Medicare Part B.

Description of Proposal

The proposed change would require Medicare supplemental policies (Medigap) to have an annual open enrollment period of 30 days.

Effective Date

January 1, 1996.

5. Reduction in Routine Cost Limits for Home Health Care Services

Present Law

Home health care services are reimbursed on a reasonable cost basis, subject to aggregate cost limits which are updated annually. The Omnibus Budget Reconciliation Act of 1987 limited payment for home health agency costs to 112 percent of the mean labor-related and non-labor per visit costs for freestanding home health agencies (HHAs). OBRA 1993 prohibited the Secretary from applying an update factor to the cost limits for home health services for cost reporting periods beginning in fiscal years 1994 and 1995. OBRA 1993 also eliminated additional payments for administrative and general costs of hospital-based HHAs.

Description of Proposal

The upper limit on payment for allowable visit-related costs for home health services would be limited to 100 percent. The cost limits are changed from a percentage of the mean cost to a percentage of the median cost.

Effective Date

October 1, 1995.

6. Improvements in Risk Contracts

Present Law

Approximately 5 percent of beneficiaries are enrolled in health maintenance organizations (HMOs) under risk contracts with Medicare. Under risk contracts, Medicare pays HMOs 95 percent of the estimated amount it would have cost to provide Medicare benefits to demographically comparable beneficiaries in the same county who had not enrolled in an HMO. The payment amount is the average adjusted per capita cost (AAPCC).

Description of Proposal

Health plans entering into Medicare risk contracts would be required to meet the standards for integrated health plans specified in Part XV. Such plans would also be required to maintain compliance with the following: (1) Section 1876 (f), which requires that at least 50 percent of enrolled membership consists of non-Medicare or Medicaid eligible individuals; (2) Section 1876 (i)(7), which requires that health plans with a risk contract maintain an agreement with a utilization and quality control peer review organization; and Section 1876 (i)(6), which authorizes

the Secretary to impose civil monetary penalties and other sanctions for failure to provide medically necessary items and services, charging premiums in excess of those permitted, and other violations.

The Secretary would be required to use community-rating areas, rather than counties, as the basis for calculating the AAPCC. The Secretary would be required to provide uniform marketing materials to all Medicare beneficiaries in a community-rating area for purposes of enrolling in a health plan.

Effective date

January 1, 1996.

E. MEDICARE AND MEDICAID COVERAGE BANK DATA

Present Law

The Omnibus Budget Reconciliation Act of 1993 established a Medicare and Medicaid Coverage Data Bank within the Department of Health and Human Services. The Secretary was required to establish the data bank for the purposes of identifying and collecting from third parties responsible for payment of health care items and services furnished to Medicare beneficiaries, and assisting in the collection of, or collecting amounts due from third parties liable to reimburse costs incurred by any State plan under the Medicaid program. Employers are required to report certain information to the Data Bank concerning employee health coverage on an annual basis for years beginning with calendar year 1994 and ending with calendar year 1997. The first filing is to occur on February 28, 1995.

Description of Proposal

The proposal would repeal the Medicare and Medicaid Coverage Data Bank.

Effective Date

Upon enactment.

XI. ACADEMIC HEALTH CENTERS, GRADUATE MEDICAL AND NURSING EDUCATION, AND RESEARCH

A. ACADEMIC HEALTH CENTERS TRUST FUND

Present Law

The Indirect Medical Education (IME) adjustment factor under Medicare's prospective payment system for inpatient hospital services increases payments to teaching hospitals compared with non-teaching hospitals. The IME payments are intended to reflect differences in patient care costs due to the indirect costs associated with graduate medical education, the severity of illness treated, and the complexity of highly specialized care. Payments to major teaching hospitals based on diagnosis-related groups (DRGs) are increased by about one-third, under a statutory formula that increases payments for each discharge by about 7.65 percent for each 0.1 increase in the ratio of residents to beds (section 1886(d)(5)(B)(ii) of the Social Security Act). The formula is calculated on a curvilinear basis, so that the increase in the payment tapers off somewhat in hospitals with very high resident-to-bed ratios.

Description of Proposal

1. A trust fund would be established to make payments to teaching hospitals and to academic health centers that operate teaching hospitals, to high intensity non-teaching rural hospitals, and to dental schools for dental education.

2. Payments would be made to hospitals, academic health centers, and high intensity non-teaching rural hospitals to assist with specialized costs they incur that are not routinely incurred by other entities in providing health services and that are unlikely to be covered by payments for hospital services under managed competition.

3. An "academic health center" would be defined as a teaching hospital or a school of medicine or osteopathy that operates a teaching hospital. A teaching hospital is a hospital that operates a residency training program that is accredited by a specialty or subspecialty. A high intensity non-teaching rural hospital would be defined as one with substantially more patients who are severly ill as measured by their case mix index.

4. Annual payments from the trust fund would total $6,280,000,000 in 1996; $7,250,000,000 in 1997; $8,220,000,000 in 1998; $9,400,000,000 in 1999; $10,640,000,000 in 2000; and in each subsequent year, $10,640,000,000 increased by the change in the national premium targets (as defined in Part VI) for such years; of those sums, $50,000,000 in 1996, increased by the change in the national premium targets in subsequent years, would be available for dental education.

5. Distribution of funds among teaching hospitals and academic health centers would be according to a formula modeled after the current Medicare IME adjustment factor. The current IME payment formula, which is based on

DRGs, would be modified to reflect the varying methods of hospital payment in the private sector. It would also be adjusted to compensate for the higher costs of research-intensive academic centers and to provide for payments to dental schools for dental education. Distribution of funds to high intensity non-teaching rural hospitals would be according to a formula based on the case mix index and would result in an increase in payments of approximately five percent.

6. The Secretary of HHS would be required to report to the Committee on Finance and the Committee on Ways and Means by July 1, 1996, with any recommendations for further modifications of the formula.

7. Funds for the Academic Health Center Trust Fund would come from all payers. Medicare would contribute at the rate at which it would otherwise have made IME payments under current law. The remainder of the funds would come from a portion of a 1.75 percent assessment on premiums for health plans (including self-insured health plans). Payments in any year would be pro-rated if necessary on the basis of available funds.

Effective Date

Upon enactment.

B. BIOMEDICAL AND BEHAVIORAL RESEARCH TRUST FUND

Present Law

No provision (biomedical and behavioral research conducted or supported by the National Institutes of Health (NIH) is funded by appropriations authorized under Titles III and IV of the Public Health Service Act).

Description of Proposal

1. A Health Research Trust Fund would be established to fund expanded biomedical and behavioral research through the NIH.

2. Funds for the Health Research Trust Fund would come from a portion of the 1.75 percent assessment on premiums for certified health plans (including self-insured health plans). Payments in any year would be equal to 0.25 percent, or one-seventh of the funds raised by the 1.75 percent premium assessment.

3. Payments for biomedical and behavioral research conducted or supported by the NIH from the Trust Fund would be in addition to any monies appropriated for that purpose. Monies from the Trust Fund could not be allotted unless total NIH appropriations in that year equaled or exceeded the appropriations for the prior year.

Effective Date

Upon enactment.

C. GRADUATE MEDICAL AND NURSING EDUCATION TRUST FUND

Present Law

1. Graduate Medical and Nursing Education Trust Fund

No provision.

2. Graduate Medical Education Payments

Under Medicare's payments to hospitals, the direct costs of graduate medical education are paid separately from the DRG-based payments. Payments are made on a formula that are based on each hospital's historical costs per resident. Each hospital's costs per resident are calculated for the hospital's cost reports for fiscal year 1984, generally updated to the present. The number of residents is the weighted average number of residents who are within the minimum number of years required for board eligibility plus 1, not to exceed 5 years, and one-half the number of residents in additional years of training. Payments include resident and faculty salaries and other related direct costs.

3. Graduate Nursing Education Payments

No provision (the direct costs of training for nurses working toward the RN degree in provider-operated programs are paid by Medicare on a reasonable cost basis, but not those in graduate education programs).

4. Medical School Account

No provision.

Description of Proposal

1. Graduate Medical and Nursing Education Trust Fund

A trust fund for payments for Graduate Medical and Nursing Education and transitional payments would be established. Payments into the trust fund would consist of payments that would otherwise have been made for Medicare direct medical education under current law, plus a portion of revenues from the 1.75 percent assessment on premiums for health plans (including self-insured health plans).

2. Payments for Graduate Medical Education

The Secretary of HHS would make payments from the Trust Fund for the operation of approved graduate physician and dental training programs, beginning in calendar year 1996. Payments would total $3,200,000,000 in 1996; $3,550,000,000 in 1997; $5,800,000,000 in 1998; and in subsequent years, $5,800,000,000 increased by the change in the national premium targets for each year.

Payments to each eligible applicant would equal the full-time-

equivalent number of residents in the program multiplied by the historical costs of training residents as determined under current Medicare direct medical education law. The full-time-equivalent number of residents would be calculated as under Medicare. Both calculations would be adjusted to account for costs and residents in programs not based in teaching hospitals. Payments in any year would be pro-rated if necessary on the basis of available funds.

3. Graduate Nursing Education Payments

A program would be established to pay for the costs of graduate nurse education. Eligible applicants would be programs for advanced nurse education, nurse practitioners, nurse midwives, nurse anesthetists, and other training in clinical nurse specialties determined by the Secretary to require advanced education. The amount available for graduate nurse training programs from the Trust Fund would be $200,000,000 in 1996, increased annually thereafter by the change in the national premium targets for each year. Payments in any year would be pro-rated if necessary on the basis of available funds.

4. Medical School Account

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 and teaching. Payments would total $200,000,000 in 1996, $300,000,000 in 1997, $400,000,000 in 1998, $500,000,000 in 1999, and $600,000,000 in 2000, increased annually thereafter by changes in the national premium targets. Payments in any year would be pro-rated if necessary on the basis of available funds.

Effective Date

Upon enactment.

XII. ACCESS TO HEALTH CARE IN DESIGNATED URBAN AND RURAL AREAS

A. INVESTMENT IN INFRASTRUCTURE DEVELOPMENT

Present Law

No provision.

Description of Proposal

An infrastructure development account is created within the Health Security Trust Fund to support the development of community health networks and certified community health plans, and to provide operating and capital assistance to such networks and plans. The Secretary of Health and Human Services would be required to deposit $1.3 billion in the account annually and to administer all programs funded through the account.

"Community health networks" are organizations that provide some services included in the standardized benefit package either directly through their members or through affiliations with other entities. A network must ensure that services are available and accessible to each enrollee with reasonable promptness, and that clients have a primary care provider. The network would have to include one or more of the following: 1) institutions, physicians, and other providers serving a Health Professional Shortage Area (HPSA) or serving large numbers of medically underserved individuals; 2) qualified migrant and community health centers; 3) qualified homeless programs; 4) family planning providers; 5) HIV providers; 6) maternal and child health block grant recipients; 7) rural health clinics and other Federally Qualified Health Centers; 8) providers of services in urban areas under Title V of the Indian Health Care Improvement Act, or providers of services under the Indian Self-Determination Act; 8) State or local public health agencies; and 9) isolated rural facilities.

A "certified community health plan" is a public or nonprofit private health plan that provides a significant volume of services to medically underserved populations or individuals residing in HPSAs; includes at least one of the providers listed above under the definition of a community health network; and meets all of the other criteria of a certified health plan.

The Secretary of Health and Human Services would be required to develop standards for identifying "designated urban and rural areas" taking into account financial and geographic access to certified health plans; the availability, adequacy, and quality of providers and health care facilities; and the health status of the area's residents. States would have the authority to identify designated urban and rural areas, subject to the approval of the Secretary.

Effective Date

Upon enactment.

B. NETWORK AND PLAN DEVELOPMENT GRANT PROGRAM

Present Law

No provision.

Description of Proposal

The Secretary would be directed to award grants to public and private non-profit health care organizations to assist them in becoming community health networks and certified community health plans.

Grant funds could be used to assist in recruitment and retention of health care professionals; to develop information, billing, and reporting systems; to link providers together (including through information systems); to meet reserve requirements; and to support other activities related to developing certified community health plans and community health networks.

In awarding grants, the Secretary would be directed to give priority to networks and plans that include the largest number of entities listed under the definition of a community health network, and that are serving populations with the highest degree of unmet need.

In exchange for funding, grantees would be required to serve a designated urban or rural area, and to serve all individuals regardless of their financial and insurance status.

Effective Date

Upon enactment.

C. OPERATING ASSISTANCE

Present Law

No provision.

Description of Proposal

The Secretary would be required to use funds from the infrastructure development account to provide operating assistance to certified community health plans and community health networks to address geographic, financial, and other barriers to health care services in designated urban and rural areas. Grant funds could be used to provide consumer information and related services that will increase access to care. Related services could include rural and frontier emergency transportation systems and translation services. In exchange for funding, grantees would be required to serve a designated urban or rural area and to provide care to all individuals regardless of their financial or insurance status.

Effective Date

Upon enactment.

D. CAPITAL INVESTMENT

Present Law

No provision.

Description of Proposal

The Secretary would be directed to use funds from the infrastructure development account to provide capital assistance to community health plans, community health networks, and isolated rural facilities in designated urban and rural areas. The assistance would be provided in the form of loans, loan guarantees, and direct grants.

Funds could be used for the acquisition, modernization, conversion, and expansion of facilities, and for the purchase of major equipment, including hardware for information systems. The Secretary would be required to develop criteria for restricting the use of direct grants to urgent capital needs.

At least ten percent of the funds available for capital assistance would be reserved for applicants seeking to serve designated rural areas, provided that a sufficient number of such qualified applications were approved.

The Secretary would be required to give preference to applicants who need capital assistance to prevent or eliminate safety hazards in essential facilities; to avoid noncompliance with licensure or accreditation standards; and to improve the provision of essential services.

In exchange for receiving capital assistance, grantees would be required to serve a designated urban and rural area. They would also be required to serve all individuals regardless of their financial and insurance status.

Any loans made under this part would be required, subject to the Federal Credit Reform Act of 1990, to meet such terms and conditions as the Secretary determined to be necessary to protect the financial interests of the United States.

Effective Date

Upon enactment.

E. TELEMEDICINE DEMONSTRATION PROJECTS

Present Law

The Department of Health and Human Services and the Department of Commerce fund various telemedicine and related telecommunications projects. None of these projects are focused on developing a reimbursement methodology for telemedicine services. There is no formal interagency task force to coordinate various telemedicine projects.

Description of Proposal

The Secretary of HHS would be authorized to use $20 million from the infrastructure development account to establish telemedicine demonstration projects. Four of the projects funded under this section would be used to develop a Medicare reimbursement methodology for telemedicine services.

Health care providers located in rural areas would be eligible to receive funding under this section if they established partnerships with other community institutions to identify and implement telemedicine projects. They would be required to match Federal grants at a rate of at least twenty percent.

Grants could be used to support the establishment and operation of a telemedicine system that provides specialty consultation to rural communities; to demonstrate the application of telemedicine for preceptorship of medical and other health professions students; to pay for transmission costs, salaries, maintenance of equipment, and compensation of specialists and referring practitioners; and to facilitate collaboration among physicians and other health care providers.

The Secretary would establish an Interagency Task Force on Rural Telemedicine. The Task Force would be required to identify effective uses of telemedicine, review and coordinate evaluations of all federally funded telemedicine demonstration projects, help rural entities to conduct local needs assessments and develop consortia, and review the Health Care Financing Administration's policy for reimbursement of telemedicine services.

Effective Date

Upon enactment.

F. PROVISIONS RELATING TO INDIAN HEALTH

Present Law

Health care for Indians is primarily funded through the Indian Health Service (IHS). Tribes are currently eligible to apply to State governments for Federal money the State receives for health initiatives.

Description of Proposal

The Indian Health Service would remain as a provider of health care for the Indian population.

Indian Tribes would be eligible to apply for appropriated funds and grants created under this legislation, at levels not less than any other qualified entities.

G. OFFICE OF THE ASSISTANT SECRETARY FOR RURAL HEALTH

Present Law

The Office of Rural Health was established under the Social Security Act and resides within the Public Health Services Health Resource Services Administration.

Description of Proposal

The position of the Director of the Office of Rural Health would be elevated to the position of the Assistant Secretary for Rural Health.

Effective Date

January 1, 1996.

XIII. STATE FLEXIBILITY

Present Law

State laws that relate to employee benefit plans, other than laws that regulate the business of insurance, generally are preempted by the Employee Retirement Income Security Act of 1974 (ERISA). Some courts have interpreted this to mean that even State laws that have only an indirect effect on the cost of providing health coverage through an employer-provided health plan are preempted, even if there is no direct impact on the administration of such plans.

Description of Proposal

A. STATE LAWS THAT DO NOT AFFECT THE ADMINISTRATION OF HEALTH PLANS

Certain State laws that are intended to increase health care coverage, fund uncompensated care, or control health care costs and which do not interfere with the administration of multistate health plans would not be preempted by Federal law.

The following State laws, to the extent they do not discriminate against self-insured or other employer-provided health plans, would not be preempted: All-payer provider reimbursement systems; uniform provider rate schedules; rate surcharges and premium or other health care assessments or allowances, the proceeds of which are used to fund uncompensated care or other State health programs; and community-rating standards that do not permit variation by age, apply to a larger share of the market, or that apply before January 1, 1996.

With the approval of the Secretary of Health and Human Services (HHS), a State's all-payer provider reimbursement system or uniform provider rate schedules also would apply to Medicare beneficiaries in the State.

B. COMPREHENSIVE STATE PROGRAMS

A comprehensive State program for the management of all health care benefits provided in the State, if approved by the Secretary of HHS, would not be preempted by Federal law. With the permission of the Secretary, the program also would apply to Medicaid and Medicare beneficiaries in the State.

To secure HHS approval, the State program would have to demonstrate that it would be expected to significantly increase coverage or lower health care spending in the State relative to baseline projections. Examples of the type of program for which a State may seek approval include a State single-payer or other public plan, an employer mandate, a combination of public and private coverage, or managed competition. The State program could not increase Federal outlays to the State.

Any certified self-insured Taft-Hartley multiemployer plan that covers participants in two or more States, or any certified single-employer plan

maintained by a multistate employer that has at least 5,000 employees nationally, would not have to participate in an approved State benefits management program.

Effective Date

For State laws that are not preempted under paragraph A, the provision would be effective before and after the date of enactment of the proposal. The Secretary would be permitted to approve comprehensive State benefit management programs described in paragraph B after the date of enactment.

XIV. PRIVACY AND CONFIDENTIALITY

Present Law

The Privacy Act of 1974 and the Computer Security Act of 1987 address the protection and disclosure of information under Federal control. The Federal Freedom of Information Act, which requires disclosure of many Federal records, explicitly excludes from disclosure most individual medical files held by the Federal government. Federal law also specifically protects the confidentiality of patient records held by alcohol and drug abuse treatment programs receiving Federal assistance.

Description of Proposal

A. RULE OF NONDISCLOSURE FOR PROTECTED HEALTH INFORMATION

All health information that could reasonably be related to a specific individual would be protected from disclosure. Comprehensive protections of this protected health information would apply regardless of form or medium, whether kept in paper files or in electronic databases, whether retained in doctors' offices or insurance company files, or available from an information system or over a computer network.

B. PENALTIES

Unauthorized disclosures of protected health information would be subject to criminal sanctions, civil actions, and administrative penalties. Penalties would range from fines of up to $50,000 and prison terms of up to one year for wrongful disclosure or obtaining of protected health information, to fines of up to $100,000 and prison terms of up to five years for violations committed under false pretenses, to fines of up to $250,000 and prison terms of up to ten years for offenses committed with intent to sell protected health information for commercial advantage or personal gain.

C. INDIVIDUAL AUTHORIZATION OF DISCLOSURES

An individual would be able to authorize disclosure of protected health information about himself or herself under circumstances that ensure the authorization is a knowing and meaningful choice, that circumscribe the uses of the disclosure, and that allow for time limitation and revocation of permission. Requests for authorization for disclosure would be structured to serve these purposes.

D. LIMIT ON AMOUNT OF INFORMATION DISCLOSED

When protected health information is disclosed, it would be limited to the minimum necessary to accomplish the purposes for which the information was disclosed.

E. PROHIBITION OF REDISCLOSURE

Protected health information obtained in accordance with law for a necessary and limited purpose could not be redisclosed or used for an unauthorized purpose.

F. PATIENT RIGHTS

An individual would have the right to inspect and annotate records of health information about himself or herself through his or her health care providers. He or she would also have the right to prohibit the disclosure of sensitive and personal information so that it would not be included in the health information that providers are otherwise permitted to share.

G. SECURITY AND INTEGRITY SAFEGUARDS

Administrative, technical, and physical safeguards of the security and integrity of protected health information would be required of all trustees of such information.

H. EXCEPTIONS TO THE RULE OF NONDISCLOSURE

An exception to the rule of nondisclosure would be created for each of the following:

1. Health Care

Health care providers would be permitted to share relevant protected health information in the process of diagnosis and treatment.

2. Payment for Health Care

Health care providers and plans would be permitted to share protected health information for the purposes of payment and for such other financial and administrative functions as necessary to the effective operations of the health system.

3. Oversight of Health Care

Oversight agencies would be permitted to have access to protected health information in order to deter, uncover, and remedy health care fraud and other abuses of the health care system. Except for an action or investigation arising out of receipt of health care or payment for health care, no information about an individual disclosed for oversight purposes could be used in an action against the individual.

4. Public Health

Disclosure of protected health information required to meet the requirements of public health authorities and the need for disease and injury reporting, public health surveillance, and public health investigations or interventions would be permitted.

5. Medical Emergencies

Disclosure of protected health information required to protect the health of an individual from imminent harm would be permitted. Disclosures pursuant to this exception could not be used in an action against the individual who was the subject of the information disclosed.

6. Health Research

Disclosure of protected health information to health research projects, for which an institutional review board has determined that disclosures are necessary, would be permitted. Use of the protected health information would be limited to the research project and identifying information would have to be kept secure and confidential. For research that involves direct contact with the subject of the information, the subject would have to be given prior notice and given an opportunity to object to being included in the research project.

7. Judicial Procedings

Court ordered examinations and disclosure of protected health information when a party has placed his or her medical condition at issue would be permitted. Disclosure would be limited to the minimum necessary and could be used only for the purpose for which it was received.

8. General Law Enforcement Requests

Disclosure of protected health information would be permitted to law enforcement authorities to investigate or prosecute a health care provider or plan or to identify a victim or witness in a law enforcement inquiry. Disclosed information could not be used against the subject of the protected health information.

9. Subpoenas and Warrants

Disclosure of protected health information would be permitted when ordered by a subpoena or warrant. A probable cause standard of reason to believe the protected health information was relevant to a law enforcement inquiry would be provided and an opportunity for an individual to move to quash the warrant or subpoena would be included for general law enforcement subpoenas or warrants. For private party subpoenas, the party seeking the protected health information would have to justify to the court that the need for the information outweighs the intrusion into privacy.

Effective Date

Upon enactment.

XV. HEALTH PLAN STANDARDS

Present Law

The Secretary of HHS determines whether Health Maintenance Organizations (HMOs) meet standards for Federal qualification.

A. STANDARDS FOR ALL HEALTH PLANS

Description of Proposal

The Secretary, in consultation with the Health Plan Standards and Quality Advisory Committee (established below), would develop specific standards and evaluation criteria to be used in the certification of all health plans. These standards would be based on the following general standards set in law.

To be certified by the State, or in the case of a multistate self-insured plan by the Secretary of Labor, all health plans must conform to the following standards.

1. Health plans would be required to establish alternative dispute resolution procedures.

2. Health plans would be required to participate in the Health Information Network. Health plans would be required to have procedures to report to the Consumer Information Center, in a standardized format, the data required to produce comparative value information. Health care professionals and facilities would be required to report a standard set of data to the Consumer Information Center.

3. Health plans would be required to meet capital and solvency standards.

a. Guaranty Funds

Each state would be required to establish and operate two guaranty funds, each of which could assess up to 2% of health plan premiums each year to cover outstanding claims against failed health plans. One fund would cover self-insured plans, and the other would cover insured plans. All health plans (other than multistate self-insured plans) would be required to participate in the appropriate guaranty fund.

A Federal fund would be established for multistate self-insured plans.

b. Capital Requirements

The Secretary, in consultation with the National Association of Insurance Commissioners, would be required to develop a risk-based capital

standards formula for all insured health plans by July 1, 1995.

Nothing in Federal statute would preclude or preempt state law on, or regulation of, health plan deposit reserve requirements.

The Secretary, in consultation with the Health Plan Standards and Quality Advisory Committee, would be required to develop capital requirements for self-funded plans.

B. ADDITIONAL STANDARDS FOR INTEGRATED HEALTH PLANS

In addition to the standards under Section A, integrated health plans would be required to meet the following standards. An integrated health plan is organized to provide health care services, either directly or through arrangements with other providers, to an enrolled population in a service area. Integrated health plans can be self-insured or insured.

1. Quality Standards

a. Quality Improvement and Assurance

Integrated health plans would be required to develop and implement an internal quality improvement program designed to measure, assess and improve enrollee health status, enrollee outcomes, enrollee processes of care, and enrollee satisfaction.

Integrated health plans would be required to develop and implement quality improvement goals based on the results of population health status measurements.

Integrated health plans would be required to maintain a program to assure the quality of health care services furnished to enrollees meets minimum standards of safety and clinical practice.

b. Utilization Management

Integrated health plans would be required to use practicing health professionals with appropriate clinical training in making review determinations.

Integrated health plans would be required to base utilization management on current scientific knowledge, stress health outcomes, rely primarily on evaluating and comparing practice patterns rather than routine case-by-case review, and be consistent and timely in application.

Utilization management could not create direct financial incentives for reviewers to reduce or limit medically necessary or appropriate services.

Upon request, each integrated health plan would be required to disclose to a participating or prospective provider, enrollee or

prospective enrollee, utilization review protocols. The standards would address the need to protect proprietary business information.

c. Credentialing

Integrated health plans would be required to credential participating physicians and practitioners.

Integrated health plans would be required to ensure that participating providers and facilities are appropriately accredited, certified and licensed.

d. Continuity of Care

Integrated health plans would be required to develop and implement mechanisms for coordinating the delivery of care across provider settings.

e. Medical Recordkeeping

Integrated health plans would be required to maintain an adequate patient record system to assure that pertinent information is readily available to appropriate professionals.

2. Patient Protection Standards

a. Patient Information

Integrated health plans would be required to provide to enrollees clear descriptive information and information about their rights and responsibilities.

b. Advance Directives

Each integrated health plan would be required to notify enrollees of their rights to self-determination in health care decision-making, notify enrollees of the plan's policy regarding advance directives, and provide for educational activities for patients and providers. Patients' primary care physicians would be required to include in the patients' charts their wishes concerning advance directives.

c. Confidentially of Patient Records

Integrated health plans would be required to have explicit procedures to protect the confidentiality of individual patient information.

d. Marketing (does not apply to self-insured plans)

Integrated health plans could not engage in selective marketing that would have the effect of avoiding high-risk subscribers within a health plan service area. Marketing materials could not contain false or materially misleading information.

e. Grievance Procedure

Integrated health plans would be required to establish a grievance process for patients dissatisfied with matters other than denial of payment or provision of benefits by the plan.

f. Consumer Protection

Integrated health plans would be prohibited from engaging, directly or through contractual arrangements, in any activity, including the selection of a service area, that has the effect of discriminating against an individual on the basis of health status, disability or anticipated need for health services.

In selecting among providers of health services for membership in a provider network, or in establishing the terms and conditions of such membership, an integrated health plan may not engage in any practice that has the effect of discriminating against a provider based on the health status, disability, or anticipated need for health services of a patient of the provider.

g. Physician Incentive Plans

Physician incentive plans operated by integrated health plans would have to meet the requirements of section 1876(i)(8)(A) of the Social Security Act, including the provision that no specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services to enrollees.

h. Physician Participation

Integrated health plans would be required to ensure that physicians participate in policymaking affecting patient care, and that patients would be able to choose their primary care physician from available practitioners.

Integrated health plans would be required to provide notification to physicians of decisions to cancel or deny renewal of contracts and establish an internal review process for appeals.

i. Ethical Business Conduct

An integrated health plan would be required to develop and implement a code of ethical business conduct for its activities, including those of its components, and assure proficient management and planning functions.

j. Enrollment

An integrated health plan could not accept the enrollment of an individual who is currently enrolled in another health plan.

3. Access Standards

a. Essential Community Provider

Integrated health plans would be required to have a contractual relationship with Essential Community Providers that included adequate payment rates for services.

The Secretary would be required to certify as an Essential Community Provider (i) migrant health centers; (ii) community health centers; (iii) homeless program providers; (iv) public housing providers; (v) family planning clinics; (vi) service units of the Indian Health Service; (vii) HIV providers; (viii) public and private non-profit entities furnishing prenatal, pediatric, or ambulatory services to children, including children with special health care needs (ix) Federally qualified community health centers and rural health clinics; (x) providers of school health services; (xi) community networks receiving development funding in designated urban and rural underserved areas; (xii) non-profit hospitals meeting the criteria for public hospitals which are eligible entities under section 340B of the Public Health Service Act -- Medicare disproportionate share adjustment exceeding 11.75 percent -- and children's hospitals meeting comparable criteria determined appropriate by the Secretary.

During the four year transition, the Secretary could set standards for the designation of additional health professionals and institutions as Essential Community Providers if the Secretary determines that health plans operating in areas served by the applicant would not be able to assure adequate access to the comprehensive benefit package without contracting with the applicant. The Office of Technology Asessment would be required to conduct a study on improving access in underserved areas.

Essential Community Provider provisions would be in effect for five years.

b. Capacity to deliver services to enrollees.

After the expiration of Essential Community Provider provisions, integrated health plans would be required to have within their network, or contract with, a sufficient number, distribution, and variety of providers to assure that the standardized benefit package and any supplemental benefits are available and accessible in all parts of state-defined service areas, with reasonable promptness and in a manner which assures continuity. Emergency services would be required to be available and accessible twenty-four hours a day and seven days a week.

c. Capability to deliver services to enrollees.

Integrated health plans would be required to make available and accessible, translation, case management, and transportation services, if necessary to deliver the standardized benefit package, and any supplemental benefits.

Integrated health plans would be required to ensure that criteria for the selection of participating providers take into account the needs of

diverse populations.

The Essential Community Provider, capacity to deliver services to enrollees, and capability to deliver services to enrollees standards (Sections a,b,c) would apply to self-insured plans only to the extent necessary to deliver services to employees.

d. Specialized services

Integrated health plans would be required to have within their network, or contract with, a sufficient number, distribution, and variety of providers of specialized services to assure that such services would be available and accessible to adults, children, and persons with disabilities.

Integrated health plans would be required to demonstrate that adults, children, and persons with disabilities have access to specialized treatment expertise by meeting evaluation criteria established by the Secretary.

Integrated health plans could meet this criteria by referring adults, children, and persons with disabilities requiring specialized services to designated Centers of Excellence.

Centers of Excellence in the field of institutional care would deliver care for complex cases requiring specialized treatment and also meet two or more of the following requirements:

i. Provide specialized education and training through approved graduate medical education programs with multi-specialty, multi-disciplinary teaching and services in both inpatient and outpatient settings, with medical staff with faculty appointments at an affiliated medical school;

ii. Attract patients from outside the center's local geographic region, from across the state or nation;

iii. Either sponsor or participate in, or have medical staff who participate in, peer-reviewed research.

The Secretary would be required to designate Centers of Excellence.

The Secretary would be required to establish evaluation criteria for health plans who choose to provide specialized services and treatments within network, including requirements for staff credentials and experience, and requirements for measured outcomes in the diagnosis and treatment of patients. The Secretary would develop evaluation criteria for outcomes of specialized treatment as research findings become available.

C. ADDITIONAL STANDARDS FOR FEE-FOR-SERVICE HEALTH PLANS

In addition to the standards under Section A, fee-for-service health

plans would be required to meet the following standards. Fee-for-service health plans do not have formal provider relationships. Payments are made to doctors chosen by the insured individuals. These plans can be self-insured or insured.

1. Quality Standards

The Secretary would be required to develop minimum standards applicable to fee-for-service health plans.

2. Patient Protection Standards

The Secretary would be required to develop minimum standards applicable to fee-for-service health plans.

3. Balance Billing

Fee-for-service plans would be required to establish a participating physician program under which physicians in the community would agree to take the plan's payment schedule as payment in full, and not to charge patients more than the 25 percent co-insurance. Each such plan would be required to make available the list of participating physicians to enrollees. Each plan would be required to have an appropriate number of physicians in each specialty as participating physicians.

D. ACCREDITATION, CERTIFICATION, AND ENFORCEMENT OF STANDARDS FOR CERTIFIED HEALTH PLANS

1. Accreditation and Certification

The Secretary would be required to develop guidelines for Accreditation, Certification, and Enforcement (ACE) programs, and approve ACE programs as meeting Federal guidelines.

The Secretary of Labor would be required to carry out all activities for certifying multistate self-insured plans.

States would be required to develop ACE programs to certify all health plans except multistate self-insured plans. States would be encouraged to use private accreditation organizations. The establishment of an ACE program would be a condition for receiving Medicaid funds.

2. Enforcement

Health plans not certified as meeting Federal standards would be subject to a civil penalty not to exceed 50 percent of gross premiums (50 percent of health expenses for self-insured plans), enforceable by the State.

Intermediate sanctions available to States would include prohibiting new member enrollment, allowing existing members to leave with no

penalties, and civil monetary penalties.

For health plans that do not meet certification requirements, State ACE programs may operate a health plan to provide transitional access, develop a correction program for the plan, or develop other options.

No Federal health care subsidies would be paid to any health plan not certified as meeting Federal standards.

3. Funding

The Secretary would be required to distribute funds to States from the Health Security Trust Fund in the amounts of $100,000,000 in 1995, $250,000,000 in each of 1996-1998, and $175,000,000 in each of 1999-2004 for State ACE programs.

The Secretary would be required to develop a bonus payment schedule for States that institute Independent Review Committees to provide recommendations concerning health plans that fail certification.

Health plans and providers would be required to pay fees directly to the accrediting or certifying body.

E. NATIONAL HEALTH PLAN STANDARDS AND QUALITY ADVISORY COMMITTEE

The Secretary would be required to establish a National Health Plan Standards and Quality Advisory Committee by July 1, 1995 to advise on standards and evaluation criteria to be used in the certification of all health plans.

The Health Plan Standards and Quality Advisory Committee would interact with the Board of the Health Security Trust Fund concerning funding and program accountability.

Effective Date

The Secretary would be required to establish standards by April 1, 1995. Health plans would be required to be certified by January 1, 1996. States would be required to meet minimum Federal standards for guaranty funds and capital by January 1, 1996.

F. PREEMPTION OF CERTAIN STATE LAWS

Present Law

No provision.

Description of Proposal

1. Laws Pertaining to Managed Care

State laws would be preempted to the extent that they constrain the development of managed care plans. In particular, such laws would be preempted if they have the effect of making it unlawful for plans that are not fee-for-service plans (or fee-for-service components of plans) to do the following:

(1) limit the number and types of participating providers;
(2) require enrollees to obtain care from participating providers;
(3) require enrollees to obtain referrals for specialty treatment;
(4) establish different payment rates for network and non-network providers;
(5) create incentives for the use of participating providers;
(6) use single source suppliers for pharmacy services, medical equipment, and other supplies and services.

2. Laws With Respect to the Corporate Practice of Medicine

State laws related to the corporate practice of medicine would be preempted to the extent that they would apply to health plans that are not fee-for-service plans and their participating providers.

3. Laws With Respect to Health Professional Licensure

State laws restricting through licensure or otherwise the practice of any class of health professionals beyond what is justified by the skills and training of such professionals would be preempted.

Effective Date

January 1, 1996.

XVI. QUALITY, CONSUMER INFORMATION, AND HEALTH SERVICES RESEARCH

Present Law

A. ADMINISTRATION

No provision.

B. HEALTH SERVICES AND QUALITY IMPROVEMENT RESEARCH

The Secretary of HHS, through the Agency for Health Care Policy and Research (AHCPR) and the Health Care Financing Administration (HCFA), conducts and supports general health services research. AHCPR conducts and supports research on medical effectiveness and outcomes partially funded by the Hospital Insurance Trust Fund, and also funds the development of medical practice guidelines.

C. QUALITY IMPROVEMENT FOUNDATIONS

No provision.

D. CONSUMER INFORMATION

No provision.

E. REMEDIES AND ENFORCEMENT

An insured's remedies for denial of a benefit depend on whether the person is covered through an employment-based plan or through a plan purchased directly by the person. If the plan is an employee benefit plan, whether self-insured or insured, the remedies are limited to those provided under ERISA. If the plan is purchased by the individual and is not an employee benefit plan, remedies are determined under State law.

Under ERISA, plans must provide a process for reviewing claim denials within specific time periods. If the appeal fails again within that review process, the individual may file suit in State or Federal court. The court may award the person the benefits denied, as well as attorney fees and costs, may impose statutory penalties, and may grant declaratory or injunctive relief. Under ERISA, however, the court may not impose compensatory or punitive damages.

If the plan is not an employee benefit plan, and is one that the individual purchased directly, the individual may be awarded whatever damages are available under prevailing State law.

Description of Proposal

A. ADMINISTRATION

The National Health Plan Standards and Quality Advisory Committee established under Part XV would advise the Secretary of HHS concerning national quality performance measures, population health status measures, comparative value information criteria, and other aspects of quality and consumer information.

The Secretary would be required to produce an annual report which reviews the quality improvement research, evaluates quality improvement foundations and consumer information, tracks the evolution of national performance measures and other research, and discusses State, regional, and national trends on quality of health care.

B. HEALTH SERVICES AND QUALITY IMPROVEMENT RESEARCH

The Secretary would direct AHCPR and HCFA to conduct and support research on the effects of health care reform on health delivery systems and methods for risk adjustment.

AHCPR would be required to give priority to supporting research and evaluation on medical effectiveness through outcomes research, practice guidelines, technology assessment, and development of dissemination and implementation techniques.

The Secretary, in consultation with public health experts and the Health Plan Standards and Quality Advisory Committee, would be required to develop and define methods to measure population health status, including risk factor assessment.

The Secretary would be required to establish criteria for, develop, and continuously upgrade national quality performance measures for consumer information and evaluation of health care services.

To accomplish these purposes, there would be authorized to be appropriated $150,000,000 for fiscal year 1995, $400,000,000 for fiscal year 1996, $500,000,000 for fiscal year 1997, and $600,000,000 for each of the fiscal years 1998 through 2004, in addition to other authorizations of appropriations available for these purposes.

C. QUALITY IMPROVEMENT FOUNDATIONS

States would be required to establish independent, community-based, non-profit Quality Improvement Foundations. The Secretary would be required to develop standards which the Foundations would be required to meet. The Quality Improvement Foundations would be required to conduct activities to translate practice guidelines into clinical practice at the local and regional levels; to provide technical assistance to health plans and providers by identifying patterns of health care delivery, health

outcomes, and health status; to sponsor collaborations in quality improvement; and to develop programs in lifetime learning for health care professionals and patient education.

Quality Improvement Foundations would be governed by a board appointed by the Governor of the State. The board would be required to have a majority of members with no substantial personal, business, professional or pecuniary connection with health care organizations, education, or research. Other members of the board would include health professionals and representatives of health plans and providers, purchasers and consumers of care, and representatives of Academic Health Centers and Schools of Public Health.

The Secretary would be authorized to pay the States from the Health Security Trust Fund $100,000,000 in 1995, $150,000,000 per year in 1996-1997, $200,000,000 per year in 1998-1999, and $250,000,000 per year for 1998-2004 for the Quality Improvement Foundations.

D. CONSUMER INFORMATION

States would be required to establish Consumer Information Centers to produce annual, standardized comparative value information on the performance of all health plans in each community rating area, distribute, educate and provide outreach for consumers on comparative value information, and receive and seek to resolve complaints.

States would be authorized to establish Consumer Information Centers directly or through non-profit organizations selected by a competitive process.

Consumer Information Centers would be governed by a board appointed by the Governor of the State. The board would be required to have a majority of members with no substantial personal, business, professional or pecuniary connection with health care organizations, education, or research. Other members of the board would include health professionals and representatives of health plans and providers, purchasers and consumers of care, and representatives of Academic Health Centers and Schools of Public Health.

The Secretary would be required to create model formats for comparative value information, develop methods for case-mix adjusted comparisons, provide guidelines for handling areas which cross State lines, develop standard design and sampling strategies for consumer surveys, and provide technical assistance and training.

The Secretary would develop criteria for the Consumer Information Centers and determine whether each State meets the criteria. If the State fails to develop the program, the Secretary would be required to take the actions necessary to implement a comparable program.

The Secretary would be authorized to pay the States from the Health

Security Trust Fund $100,000,000 in 1995, $250,000,000 per year in 1996-1998, and $175,000,000 per year for 1999-2004 for the Consumer Information Centers.

E. REMEDIES AND ENFORCEMENT

Individuals would have the same remedies for a denial, reduction or termination of benefits regardless of whether their plan is an employee benefit plan or an individual insurance policy.

Each plan would be required to provide notice of benefit denial, reduction or termination to enrollees. The plan would be required to establish an appeals process that includes procedures for the review of an initial decision, and for reconsideration of an adverse decision.

After the plan's appeals process renders a final decision, individuals would be free to pursue other remedies. These remedies would include participating in a State-run complaint review process, taking part in a non-binding dispute resolution program established by the State, or filing suit in State or Federal court.

Each participating State would be required to establish a complaint review process to hear complaints and render decisions with respect to benefit denial, reduction, or termination. The complaint review office would operate under procedures that include the use of independent medical experts, special processes in the case of emergency and urgent situations, and specific standards of evidence. If the review officer ruled that a plan had acted unreasonably in denying, reducing or terminating benefits, the officer could award all appropriate relief. States would also be required to establish dispute resolution procedures to provide an opportunity for mediation of the claim.

If the individual elected not to pursue the complaint review process, or if the individual pursued mediation but that process did not lead to a settlement, the individual would be permitted to file suit in any court of competent jurisdiction. If the court ruled that a plan had acted unreasonably in denying, reducing or terminating benefits, the court could award all appropriate relief.

The Secretary would be authorized to pay the States from the Health Security Trust Fund $100,000,000 in 1995, $150,000,000 per year in 1996-1998, and $100,000,000 per year for 1999-2004 for establishing and maintaining the complaint review and dispute resolution procedures.

Effective Date

Upon enactment.

APPENDIX: HEALTH PLAN LEXICON

1. **Certified Health Plan.**--A standard health plan or a very high deductible health plan certified as meeting insurance reform, quality, and other standards set forth in this proposal.

   a. **Standard Health Plan.**--A health plan described in Part IV of this proposal that provides the standard benefits package. A standard health plan can be a fee-for-service plan or an integrated plan such as a health maintenance organization, and can be insured or self-insured.

   b. **Very-High Deductible Health Plan.**--A health insurance policy described in Part IV of this proposal that covers the standard set of services but with a deductible of $5,000 for individuals and $10,000 for families.

2. **Certified Supplemental Health Benefits Policy.**--A health plan described in Part IX of this proposal that covers services and benefits not covered under a certified health plan. A supplemental health benefits policy can be insured or self-insured. A certified supplemental health benefits plan is not a certified health plan.

3. **Certified Long-Term Care Insurance.**--An insurance policy described in Part IX that covers long-term care services. A certified long-term care policy is not a certified health plan.

6/27/94
6 p.m.

MAINSTREAM COALITION PROPOSED AGREEMENT

PART ONE - COVERAGE

I. INSURANCE COVERAGE

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

A. Assurance of Universal Coverage

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

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

   b. Structure of delivery system;

   c. Number, organizational form of health plans;

   d. Level of enrollment in health plans;

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

   f. Status of insurance reforms;

   g. Development of purchasing groups and other buyer reforms;

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

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

j. Adequacy of subsidies for low income individuals;

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

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

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

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

o. Evaluation of adequacy of benefit packages.

B. Coverage Trigger

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

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

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

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

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

c. Possible adjustments to the benefits package;

d. Possible adjustments to subsidies; and,

e. Possible adjustments to tax treatment of benefits.

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

A. Rules for the Senate

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

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

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

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

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

5. 30 Hours of consideration

a. Two hours for first degree relevant amendments

b. One hour for each relevant second degree amendment.

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

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

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

B. Rules for the House of Representatives

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

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

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

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

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

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

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

C. Health Care Coverage Area

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

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

D. Insurance Market Reforms

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

1. Guarantee issue to all qualified applicants.

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

3. Guarantee renewal to all qualified enrollees, except in instances of non-

payment of premiums or fraud or misrepresentation.

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

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

6. Comply with enrollment process.

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

E. Benefit Packages

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

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

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

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

2. Categories:

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

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

3. Priorities:

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

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

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

c. Improving the health of Americans through prevention.

4. Medically Necessary or Appropriate

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

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

a. For treatment of a medical condition.

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

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

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

5. Cost-Sharing

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

6. Limitations

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

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

a. Develop interim coverage decisions in limited circumstances.

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

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

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

8. Consideration of Commission Recommendations

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

II. Qualified Health Plans

A. Accountable Health Plans (AHPs)

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

2. Standards

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

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

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

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

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

e. Must provide for the application of coverage standards (for benefits) which are consistent with the coverage standards issued by the Commission and disclosed to plan enrollees.

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

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

h. Must comply with federal information requirements.

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

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

B. Employer-Sponsored (risk-bearing) Plans

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

2. Standards:

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

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

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

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

C. Qualified Association Plans (QAPs)

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

2. Standards:

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

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

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

3. Requirements for Sponsoring Entity (Association)

   a. Must be organized and maintained in good faith.

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

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

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

   e. Must receive the active support of its membership.

4. Treatment of Multiple Employer Welfare Arrangements (MEWAs)

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

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

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

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

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

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

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

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

D. Multi-Employer (Taft-Hartley) Plans

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

E. Public Programs

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

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

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

1. State laws that restrict plans from:

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

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

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

d. establishing different payment rates for participating providers;

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

2. State corporate practice of medicine laws;

3. State mandated benefit laws.

G. Advance Directives

1. Right to Self-Determination

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

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

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

2. Decisions by Surrogates

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

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

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

i. the spouse, unless legally separated;

ii. an adult child;

iii. a parent; or

iv. an adult brother or sister.

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

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

III. Large and Small Employer Responsibilities and Purchasing Groups

A. Small Employer Purchasers

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

2. Responsibilities:

a. May not be the sponsor of a risk-bearing plan, but if a member of an eligible Association may join a QAP.

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

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

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

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

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

B. Large Employer Purchasers

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

2. Responsibilities:

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

b. Large employers are ineligible to join the small employer and individual purchasing groups or to purchase insurance at the

community rate either through a broker, independent agent, purchasing cooperative, or public enrollment office.

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

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

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

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

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

C. Individual and Small Employer Purchasing Groups

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

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

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

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

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

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

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

D. Allowing Access to Federal Employee Health Benefit Program

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

IV. Nondiscrimination provisions that apply to all employers:

A. General Rules

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

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

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

B. Special Rule for Small Employers

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

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

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

C. Penalties

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

D. Definitions

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

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

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

E. Exemption for Collectively Bargained Plans

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

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

A. Eligibility:

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

B. Amount of Voucher

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

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

C. Phase-in Schedule for Vouchers

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

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

D. Administration of Vouchers

1. The Secretary of HHS will establish a mechanism for determining eligibility for vouchers, for distributing application

forms, and to the extent practicable, for allowing enrollment in a Qualified Health Plan at the time of application for subsidy.

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

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

VII. Expanding Access for Underserved Populations

A. Community-Based Primary Care Grant Program

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

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

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

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

B. Enhanced Assistance for Federally Qualified Health Centers

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

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

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

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

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

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

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

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

F. Office of the Assistant Secretary for Rural Health

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

G. Rural and Frontier Emergency Care

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

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

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

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

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

H. Medicare Dependent Hospitals

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

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

   b. conform target amounts to extension of additional payments;

   c. clarify of updates; and,

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

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

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

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

2. Rural community hospitals meeting eligibility criteria may qualify as

Rural Emergency Access Community Hospitals (REACHs).

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

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

   a. a RPCH cannot have more than 6 beds;

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

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

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

5. Designates EACH hospitals so that:

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

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

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

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

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

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

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

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

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

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

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

J. Extends the Rural Health Transition Grant Program

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

K. Increases reimbursement to PAs and NPs under Medicare

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

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

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

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

L. Telemedicine and Related Telecommunications Technology

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

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

M. National Health Service Corps

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

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

N. Indian Health Reform Amendments

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

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

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

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

O. Transitional Requirements for Plans Serving Special Needs Populations

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

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

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

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

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

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

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

b. Health Professional Shortage Areas as described in section 332(a)(1)(a) of the PHS Act;
c. High impact areas as described in section 329(a)(3) of the PHS Act; or
d. an area which includes a population group which the Secretary determines as a health manpower shortage area under Section 332(a)(1)(B) of the PHS Act.

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

a. Must be a public or non profit private entity;
b. Must be capable of providing for a full range of primary health care services that are available and accessible promptly, as appropriate and in a manner which assures continuity;
c. Have organization arrangements for quality assurance programs and maintaining patient record confidentiality;
d. Demonstrate financial responsibility;
e. Accept all patients notwithstanding their ability to pay;
f. Make every effort to collect appropriate reimbursement from Medicare, Medicaid and third party payers;
g. Establish a sliding-scale fee schedule based on ability to pay for services;
h. Reviews annually its catchment area;
i. Where appropriate, provides access to patients with limited english-speaking ability;
j. Meets the requirements of section 1861(z) of the Social Security Act, compiles appropriate statistical and other information.

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

7. Scope of Contracts
The contract between health plans shall:

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

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

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

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

9. Access in Underserved Areas

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

P. Urban " Safety-Net" Hospitals

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

Q. Other Urban Hospitals

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

VIII. New Home and Community Based Long Term Care Program

A. General

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

B. Eligibility

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

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

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

2. Presents evidence of severe cognitive or mental impairment.

3. Has severe or profound mental retardation.

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

C. Covered Services

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

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

D. Cost Sharing

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

E. State Administration

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

F. Quality Assurance

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

G. Federal Matching Payments to States

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

H. Funding, Allotments to States

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

PART TWO - COST CONTAINMENT & CONSUMER PROTECTION

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

B. Medical Liability Reform

1. Alternative Dispute Resolution

   a. No health care malpractice action may be brought in court until final resolution of the claim under an alternative dispute resolution (ADR) method adopted by the state from models developed by the Secretary of HHS, or developed by the state and approved by the Secretary of HHS.

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

2. Damages

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

3. Several Liability

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

4. Punitive Damages

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

5. Statute of Repose

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

6. Fee Reform

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

7. Limited Preemption

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

C. Administrative Simplification and Paperwork Reduction

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

1. National Health Information Network

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

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

b. transmitting information electronically,

c. conducting transactions using this information,

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

e. monitoring performance to assure compliance,

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

g. making changes to previously adopted standards, and

h. developing, testing, and adopting new standards.

2. Health Information Advisory Commission

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

3. Requirements for Qualified Health Plans and Health Care Providers

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

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

4. Accessing Health Information

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

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

5. Effective Date

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

D. Quality Assurance

The goal of health reform is to ensure that Americans have access to health care plans that compete on the basis of price and quality. Assessing quality requires reliable and comparable information on the outcomes and effectiveness of services provided by plans. Under this subtitle, Qualified Health Plans are required to annually report data on the quality of their services to the Secretary of HHS in a format prescribed under the National Health Information Network. The Secretary may determine the manner in which these data are provided to certifying authorities in states. This title also provides direction to the Secretary to improve and expand the capability of HHS to support and encourage research and evaluation of medical outcomes.

Standards and Measurements of Quality

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

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

1. setting priorities for strengthening the medical research base;

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

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

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

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

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

E. Anti-fraud and Abuse Control Program

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

1. Require the HHS Secretary and Attorney General to jointly establish and coordinate a national health care fraud program to combat fraud and abuse in government and Qualified Health Plans;

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

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

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

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

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

X. REFORM OF EXISTING PUBLIC PROGRAMS

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

1. Integration of Medicaid beneficiaries into Qualified Health Plans

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

i. the impact on private health insurance premiums,

ii. the administration of subsidies,

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

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

States may give their AFDC and non-cash eligible beneficiaries (excluding medically needy) the option to receive medical assistance through enrollment in a Qualified Health Plan offered in a local HCCA instead of through the Medicaid plan.

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

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

3. Limitation on Certain Federal Medicaid Payments

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

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

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

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

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

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

4. State Flexibility to Contract for Coordinated Care Services

a. States have the option, to establish a program under Medicaid program to allow states to enter into contracts with at-risk primary care case management (PCCM) providers.

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

c. Qualified risk contracting entities must:

i. meet federal organizational requirements;

ii. guarantee enrolled access; and,

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

(a). an experienced-based payment methodology;

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

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

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

d. Meet federal standards for internal quality assurance.

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

1. States are required to contract directly with essential community providers, or at the election of the ECP, each

risk contracting entity may enter into agreement to make payments to the essential community provider for services.

2. Essential community providers include:

   a. Federally Qualified Health Centers,

   b. Public Housing Providers,

   c. Family Planning Clinics,

   d. AIDS providers under the Ryan White Act,

   e. Maternal and Child Health Providers, and

   f. Rural Health Clinics.

B. Medicare

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

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

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

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

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

3. Medicare Select

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

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

c. Plans may not discriminate based on health status.

4. Medicare Risk Contract Program

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

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

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

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

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

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

h. The Secretary shall define Medicare market areas which shall be consistent with the health care coverage areas defined by the

non-Medicare population. For the Medicare program, the MSAs may cross state lines if the Secretary determines it is necessary to increase choices to Medicare beneficiaries. The federal contribution for a Medicare health plan will be the same throughout the Medicare market area.

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

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

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

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

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

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

5. Administrative Simplification

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

6. Study and Demonstration for Medicare Cost Containment

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

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

C. GRADUATE MEDICAL EDUCATION

[Under Discussion]

I. FINANCING

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

Savings

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

Revenues

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

* Preliminary estimate based on available information

B. Descriptions of Medicare Savings

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

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

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

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

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

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

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

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

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

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

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

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

C. Medicaid Savings

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

eliminated in FY 1996 - 15%, FY 1997 - 25%, FY 1998 - 60% and 1999 - 100% (unless 95% coverage is not reached in which case it will not be completely phased-out)

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

D. Revenues

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

2. **Tobacco Tax.** The proposal increases the tax on tobacco by $50 per thousand cigarettes ($1 per pack of 20 cigarettes). Described in Section XIII., G.)

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

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

XII. Fiscal Responsibility

Fail-Safe Mechanism

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

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

   a. Medicare Expenditures

   b. Medicaid Expenditures

   c. Health Related Tax Expenditures

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

ii. Employer deduction for health insurance premiums.

iii. 7.5% floor for deduction of medical expenses.

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

   a. Everything included in the CHSB.

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

   c. Cigarette excise tax.

   d. Vouchers for purchase of a Qualified Health Plan.

   e. High-Cost Plan Assessment

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

   a. The voucher phase-in is delayed.

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

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

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

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

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

XIII. Tax Provisions

A. High Cost Plan Assessment

1. Beginning in 1996, an annual assessment will be imposed on High Cost Plans. High Cost Plans are those health care packages whose premiums exceed a target amount. The target amount will be set by the IRS at the beginning of each year based on the premium bids submitted to the HCCA for Basic plans (Primary Basics) and Standard plans (Primary Standards). The target amount will be set at a level such that forty

percent of the plans in each area are above that amount.

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

   i. Primary Basics including the value of any supplemental benefits, and

   ii. Primary Standards including the value of any supplemental benefits.

b. An insurer then determines which, if any, of such plans are above the applicable target amount.

c. The IRS will also determine the lowest 25% of geographically-adjusted Primary Basic and Primary Standard premiums nationally. Plans (including supplemental benefits) that fall within the lowest 25% of the geographically-adjusted premiums are exempt from the High Cost Plan Assessment.

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

e. Treasury will be given the authority to develop regulations implementing this provision.

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

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

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

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

authority to develop regulations implementing this provision.

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

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

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

C. Employer-Provided Health Insurance

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

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

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

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

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

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

2. Nurse practitioners and physician assistants practicing full-time and either newly certified or newly relocated to a rural, frontier, or urban HPSA would be eligible for a similar credit equal to $500 per month up to the a total of $18,000;

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

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

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

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

E. Long Term Care Tax Provisions

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

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

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

F. Accelerated Death Benefits

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

G. Tobacco Tax

The proposal increases the tax on tobacco by approximately $16.67 per pound of tobacco for cigarettes. At proportional increase is applied to all other tobacco products. In addition it extends the tax to tobacco to be used in "roll-your-own" cigarettes. The new tax rates would be:

1. Cigarettes:

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

2. Cigars:

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

3. Cigarette papers and tubes:

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

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

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

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

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

XIV. National Health Commission

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

A. Operation

1. The Commission shall be composed of 7 members appointed by the President with the advice and consent of the Senate. The Commission members will serve 6 year overlapping terms. No more than four members of the Commission may be from the same political party. The members shall be compensated at level IV of the Executive Schedule. One member of the Commission shall be designated as the Chairman by the President.

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

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

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

B. Responsibilities

1. Clarify the standard and basic benefits packages.

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

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

d. Develop risk adjustment factors for Accountable Health Plans.

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

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