TABLE OF CONTENTS

HEALTH RESEARCH
- HEALTH PROMOTION AND DISEASE PREVENTION RESEARCH
- HEALTH SERVICES RESEARCH

CORE PUBLIC HEALTH PROGRAMS

MEDICARE
- PRESCRIPTION DRUGS
- MEDICARE AND THE ALLIANCE SYSTEM
- MEDICARE MANAGED CARE
- EXPANDED COVERAGE OF PROVIDERS
- ADMINISTRATIVE SIMPLIFICATION
- MEDICARE AND THE DEPARTMENTS OF DEFENSE AND VETERANS AFFAIRS
- MEDICARE SAVINGS

MEDICAID
- INTEGRATION OF ACUTE CARE SERVICES
- SUPPLEMENTAL PROGRAM FOR LOW-INCOME CHILDREN
- MEDICAID SIMPLIFICATION
- MEDICAID COMMISSION

LONG-TERM CARE INITIATIVES

- HOME AND COMMUNITY-BASED PROGRAM
- CONTINUATION OF MEDICAID LONG-TERM CARE SERVICES
- ELIGIBILITY IMPROVEMENTS FOR MEDICAID INSTITUTIONAL CARE
- PRIVATE LONG-TERM CARE INSURANCE REFORM
- TAX TREATMENT OF LONG-TERM CARE INSURANCE
- TAX INCENTIVES FOR INDIVIDUALS WITH DISABILITIES WHO WORK
- ACUTE CARE AND LONG-TERM CARE INTEGRATION DEMONSTRATION PROJECT

VI. QUALITY

QUALITY MANAGEMENT
- NATIONAL QUALITY MANAGEMENT PROGRAM
- HEALTH INFORMATION SYSTEMS AND PRIVACY PROTECTION
- REMEDIES AND ENFORCEMENT

MALPRACTICE REFORM
FRAUD AND ABUSE
ANTI-TRUST REFORM

VII. OTHER GOVERNMENT PROGRAMS

DEPARTMENT OF DEFENSE
DEPARTMENT OF VETERANS AFFAIRS
FEDERAL EMPLOYEES HEALTH BENEFIT PLAN
INDIAN HEALTH SERVICES

VIII. MANAGING THE TRANSITION TO REFORM

INTEGRATION OF WORKERS COMPENSATION AND AUTO INSURANCE
INSURANCE REFORM

HEALTH SECURITY ACT of 1993
EXECUTIVE SUMMARY

The Health Security Act guarantees comprehensive health benefits for all American citizens and legal residents.

Regardless of health or employment status, under the Health Security Act, coverage is secure and seamless, with no lifetime limits and without interruption when Americans lose or change jobs, move, become ill or confront a family crisis. Every American citizen will receive a Health Security card that guarantees comprehensive benefits that can never be taken away.

Six fundamental principles form the foundation of the Health Security Act:

- **Security:** The guarantee of comprehensive benefits.
- **Simplicity:** Reductions in paperwork and a simplified system.
- **Savings:** Effective steps to control rising health care costs for consumers, business and our nation.
- **Quality:** The commitment to improve quality and access to health care.
- **Choice:** The commitment to preserve and expand the choice of health plans and providers.
- **Responsibility:** The assumption of shared responsibility for health care.

Under the Health Security Act, Americans and their employers take responsibility for their health coverage and, in return, they are guaranteed the security that they will always have comprehensive benefits.

The Health Security Act creates incentives for health care providers to compete on the basis of quality, service and price. Anchored in the private market, it unleashes the power of competition and puts American consumers in the driver's seat. Consumers choose their health plans and their doctors and other providers.

Under the Act, each state sets up one or more health purchasing alliances to make health plans available to area consumers and employers. Regional alliances contract with an array of qualified health plans negotiating price and service on behalf of consumers and providing them with information on which to compare health plans. Employers with more

than 5000 workers may choose to operate their own corporate alliances. Each state tailors its approach to local needs and conditions, extending coverage to all Americans by January 1, 1998.

Through a carefully designed series of discounts and caps on required payments, the Health Security Act guarantees both American business and individuals that health costs will not exceed manageable limits.

It reforms the private health insurance market to outlaw practices that penalize small business and individual consumers. It reduces waste and frees the health care system of paperwork and regulation, allowing doctors, nurses, hospitals and other health providers to focus on providing care.

It preserves and strengthens the Medicare program for older Americans, providing a new benefit to cover the cost of prescription drugs. It launches a new initiative to increase options for home and community-based long-term care for disabled Americans of all ages.

CREATING SECURITY

The Health Security Act guarantees every American and legal resident health coverage that can never be taken away:

- Comprehensive benefits have no lifetime limits on medical coverage and provide a full range of preventive services and medically necessary or appropriate health services.

- Health plans may not deny enrollment to anyone ~~because of health, employment or financial status~~; nor may they charge some patients more than others based on age, medical condition or other individual characteristics.

- Elderly and disabled Americans receive coverage for outpatient prescription drugs under Medicare for the first time. A new program expands access to home and community-based long-term care services.

- Health coverage continues, uninterrupted, during periods of unemployment.

- Self-employed workers have access to affordable coverage and gain a federal income tax deduction for the full cost.

- Workers between the ages of 55 and 65 who retire before they are eligible for Medicare continue to receive guaranteed coverage through the alliance, and beginning in 1998, pay only the share of the premium they paid as employees.

- States qualify health plans, ensuring that they meet essential standards and deliver the comprehensive benefits package.

- Health alliances arrange to have a broad choice of health plans available from which consumers choose the plan that best suits their needs.

- The range of choice available includes at least one fee-for-service plan.

- New investments and loans improve the availability of health care in rural communities and inner-city neighborhoods.

- School-based and community clinics expand access to care in areas with inadequate health services.

- Increased federal loans, grants and financial incentives, including expansion of the National Health Services Corps, work to attract health professionals to areas with shortages of doctors and nurses.

CONTROLLING COSTS

The Health Security Act reduces the projected rate of growth in health care costs by increasing competition, reducing waste and administrative costs and imposing limits on how much premiums can rise. Health plans compete to provide affordable, quality care.

- Uniform, comprehensive health benefits and reliable information about the price and performance of health plans encourage informed choices.

  Consumers may choose to pay less for lower-cost health plans or more for higher-cost plans, creating incentives for cost-conscious decisions.

- Payments to health plans are fixed on a per person basis, providing incentives to spend resources wisely. Payments are adjusted based on the risk characteristics of each plan's participants.

If savings attained through competition and reductions in administrative burden fail to contain costs, limits on the rate of growth of insurance premiums provide an emergency brake -- or backstop -- to ensure that premiums remain in line with inflation.

Health reform also reduces the projected rate of growth in federal and state spending for Medicare, Medicaid, and other government programs. Resources conserved are invested in other aspects of the health care system, particularly the expansion of Medicare benefits to include prescription drugs and new long-term care services.

The Health Security Act cracks down on providers and institutions that overcharge or engage in health care fraud. It sets tough new standards and imposes stiffer penalties that include:

- New criminal penalties for health care fraud and for the payment of bribes or gratuities to influence the delivery of health services and coverage.
- New civil financial penalties against providers who submit false claims.
- Tighter restrictions to eliminate referral "kickbacks" and new standards that prohibit physicians from referring their patients to institutions in which they hold financial interests.
- Strong accountability standards that make misconduct by providers automatic grounds for exclusion from all health plans.

EXPANDING CHOICE

The Health Security Act guarantees consumers a choice of health plans and enhances the patient-doctor relationship.

- Alliances offer an array of competing health plans from which individuals and families choose their health coverage, expanding the range of choice for many Americans.
- Alliances must include at least one traditional fee-for-service plan.
- All health plans offer a "point-of-service" option that allows consumers to consult any doctor or other providers even when they enroll in organized networks of providers.
- Consumers -- rather than their employers -- choose their health plans.
- Doctors and other health care providers also have expanded choice about the types of health plans in which they practice medicine.

- Alliances accept all qualified health plans that can compete for enrollment, although they may decline to contract with plans whose premiums exceed the alliance's premium target by more than 20 percent.

- Alliances provide useful and reliable information -- including an annual performance report and the result of consumer satisfaction surveys -- on each health plan to help consumers choose among them.

- Separate programs increase federal support for long-term care and improve the quality and reliability of private long-term care insurance.

ENHANCING QUALITY

away from regulation and toward

The Health Security Act improves the quality of health care, reorienting quality assurance programs to measuring outcomes ~~rather than regulation~~. It also increases the national commitment to medical research and promotes primary and preventive care.

- Regular surveys of consumer satisfaction are used to measure health plans.

- Regular publication of useful and easily understood information about quality and cost allows consumers to make informed choices among health plans.

- A special funding mechanism strengthens the role of academic health centers in research, training and specialized care.

- Increased investment in research improves treatment options and the delivery of care.

- Changes in Medicare rates and the allocation of federal funds supporting graduate medical education provide new incentives for physicians to enter primary care.

- Expanded funds for education and new federal action help remove artificial barriers to practice that hinder nurses and other professionals. Moreover, changes in Medicare allow advanced practice nurses to bill the Medicare program directly.

- Investments in public health and medical research improve health protection for all Americans.

REDUCING BUREAUCRACY

The Health Security Act reduces the burden of paperwork and administration and streamlines regulatory, billing and reporting requirements.

- A comprehensive benefits package that covers every American and legal resident reduces paperwork and coordination for health care providers and consumers.

- Administrative costs caused by multiple insurance policies with different benefits and risk selection disappear.

- Standard forms for insurance claims and billing procedures simplify paperwork and reduce administrative costs.

- Federal regulatory requirements for Medicare, Medicaid and clinical laboratories are simplified.

- Health services covered by workers' compensation and automobile insurance are integrated into health insurance, reducing coordination problems, and promoting efficiency.

- Malpractice reform reduces incentives for the practice of "defensive medicine," including unnecessary tests and procedures.

SHARING RESPONSIBILITY

The Health Security Act is anchored in the conviction that generating competition over quality and price and empowering consumers to make cost-conscious choices will produce savings in both the private and the public sector.

- The Health Security Act relies on the requirement of shared responsibility for the purchase of health coverage to build a solid foundation for health security. It strengthens the private, employment-based system and augments it with a commitment to make the purchase of coverage affordable through discounts to small business and families.

- Of the additional funds required to provide coverage to all Americans, two-thirds comes from the requirement for every individual and employer to participate.

- However, the Health Security Act fulfills the commitment to universal coverage by assisting those who cannot afford coverage. A carefully designed series of discounts and caps limits the financial obligations of employers -- particularly small businesses -- and of individuals and families.

- It carries out the commitment to control the rising costs of health care for taxpayers by capping ~~both~~ the Federal Government's commitment to fund discounts for small businesses, individuals and families and by implementing specific changes in policy designed to control the projected rate of growth of the Medicare and Medicaid programs without reducing benefits or care.

- The additional costs of reform are paid primarily through an increase in the federal excise tax on tobacco products and an assessment on large corporations that choose to operate corporate alliances.

PURCHASING HEALTH COVERAGE

Under the Health Security Act, the purchase of health coverage revolves around two shares: the individual or family share and the employer share.

- Each individual or family purchases a health plan designed to cover one of four categories by family type.
    - A single adult policy.
    - A policy covering two adults.
    - A policy covering a single parent with children.
    - A policy covering two parents with children.

- Generally, employers pay 80 percent of the premium of a weighted-average cost plan for the appropriate family type policy.

- The employer's share is based on the average premium in the alliance calculated on a "per worker" basis for each family type.

- An employer may choose to pay part or all of the family share of the premium.

- The individual or family pays the 20 percent of the actual premium of the health plan in which they choose to enroll.

- As a rule, individuals and families in which at least one person is employed outside the home pay a maximum of 20 percent of the average health plan premium for their type of family in their area. Those who choose a less expensive plan pay less. Those who choose a more expensive plan pay more, as they do today.

This is misleading

- In either case, required payments are capped. Employers purchasing coverage through regional alliances are guaranteed that they will pay no more than 7.9 percent of payroll for health coverage for their workers. Businesses with fewer than 75 workers receive discounts that peg their payments to a sliding scale based on size and average wage from 3.5 to 7.9 percent of payroll.

I. UNIVERSAL COVERAGE

UNIVERSAL COVERAGE

OVERVIEW

The Health Security Act guarantees all American citizens and legal residents a comprehensive package of benefits that can never be taken away.

A Health Security Card guarantees each eligible person coverage through a health plan that delivers the comprehensive benefits package. Coverage continues with no lifetime limits regardless of a change of employer, employment status, marital status or medical condition.

Under the Health Security Act, the vast majority of Americans continues to receive health coverage through their work, as they do today, but all employers contribute to the purchase of health coverage for both full and part-time employees.

In this respect, the Health Security Act resembles the Social Security Act -- and for many of the same reasons. Making either program voluntary would raise costs, undermine security and thwart the achievement of widely shared goals of fairness and control over rising costs.

Universal participation ~~is critical to ending exclusions for pre-existing conditions. It~~ ensures that everyone receives the care they need -- and shares the responsibility to purchase it. ~~By spreading costs evenly and reducing uncertainty, universal participation makes coverage more affordable.~~

guaranteeing health coverage

~~In health coverage,~~ efficiency as well as equity argue for including everyone. While universal coverage accomplishes the primary goal of creating security, it also ensures others in the community against higher costs. They no longer pay -- through cost shifting and higher charges -- the unpaid medical bills of uninsured patients.

UNIVERSAL COVERAGE: SUMMARY OF TITLE I, SUBTITLE A

Under the Health Security Act, each eligible individual is guaranteed nationally defined, comprehensive health care benefits. Eligible individuals include:

- Citizens or Nationals of the United States.
- Citizens of other countries legally residing in the United States.
- Long-term non-immigrants.

In most cases, individuals eligible for Medicare and certain other government programs continue to receive coverage through those programs. Medicare does not change

for beneficiaries except for the addition of a new benefit covering prescription drugs beginning January 1, 1996. Beneficiaries who are working (or who are spouses of workers) will receive coverage through health alliances.

INDIVIDUAL RESPONSIBILITY

The Health Security Act provides universal coverage and in return requires all Americans and legal residents to purchase health coverage.

SUPPLEMENTAL COVERAGE

Any individual may purchase additional health services directly or through supplemental health insurance to cover services not included in the guaranteed comprehensive benefit package.

Individuals who are not eligible under the Act may purchase health insurance other than through an alliance. Employers may provide additional coverage beyond the comprehensive benefit package.

ACCESS TO COVERAGE

- Generally, individuals and families enroll in a qualified health plan through a regional health alliance that serves the area in which they reside.

- Individuals employed by firms with more than 5000 employees, members of Taft-Hartley plans with more than 5000 covered workers, and rural electric telephone cooperatives may obtain coverage through a corporate alliance if the organization or employer chooses to establish one.

- Employees of government, including federal, state, local and special-purpose agencies enroll in regional alliances, except for the United States Postal Service, which may form a corporate alliance.

- Eligible military personnel, retirees, and their families may enroll in a Uniformed Services Health Plan ~~provided~~ by the Department of Defense or ~~choose~~ another plan through the alliances.

- Veterans may enroll in a veterans health plan through the Department of Veterans Affairs -- with certain groups of veterans receiving priority for enrollment -- or they may choose another health plan through the alliances.

- Individuals eligible for the Indian Health Service may continue to receive care through its programs or may choose to enroll in a health plan through the alliance system.

- Prisoners continue to receive care from the authority holding them in custody.

- Undocumented aliens are not eligible to obtain the comprehensive benefit package through enrollment in a health plan.

EFFECTIVE DATE OF GUARANTEE

The guarantee to comprehensive benefits becomes effective when the state in which an individual resides establishes regional alliances but no later than January 1, 1998. The guarantee for individuals covered under corporate alliances takes effect on the same date.

TREATMENT OF FAMILIES

Generally, all members of a family enroll in the same health plan.

- An individual or family eligible to enroll in both a regional and a corporate alliance chooses the alliance in which to participate.

- Individuals eligible for Medicare who are employed, or have spouses who are employed for more than two months in a year enroll in a health plan through an alliance.

An exception applies to individuals fitting into the following categories.

- Recipients of the Aid to Families with Dependent Children (AFDC) program.
- Recipients of the Supplemental Security Income.
- Veterans who elect to enroll in the Department of Veterans Affairs health plans.
- Active duty military personnel
- American Indians who elect coverage through the Indian Health Service.
- Prisoners

Full-time students under 24 years of age may enroll to receive services in the regional alliance where the school is located.

II. GUARANTEED COMPREHENSIVE BENEFIT PACKAGE

GUARANTEED COMPREHENSIVE BENEFIT PACKAGE: SUMMARY OF TITLE I, SUBTITLE B

OVERVIEW

The health benefits guaranteed to all American citizens and legal residents through the Health Security Act contain no lifetime limits on coverage, and provide a comprehensive package of health services delivered through hospitals, clinics, professional offices and other sites.

One uniform, comprehensive benefit package replaces the confusing variety of insurance products on the market today. The scope of coverage is comparable to the scope of benefits offered by major employers. In one important respect -- its coverage of preventive health services -- the benefits established by the Health Security Act exceed most existing health plans.

The benefits defined in the Health Security Act are not a minimum or a floor. Rather, they are the comprehensive product that health plans compete to sell and the basis for determining employer, individual and government obligations. Requiring all plans to offer the same scope of benefits prevents plans from designing coverage to attract only healthy participants.

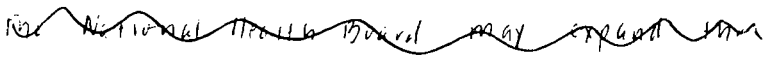
In the current system, insurers often do not provide broad coverage of prescription drugs, substance abuse services or mental health services, for example, in order to avoid attracting a less healthy population. A single comprehensive guaranteed benefits package eliminates such distortions and makes it easier for consumers to compare plans and choose among them. It also creates consistent coverage across the country, so that Americans can count on the same level of service and coverage wherever they live.

Comprehensive benefits ensure that everyone has protection against the threat of financial ruin caused by catastrophic illness, as well as genuine access to the health services they need. The best health plans in the current market generally offer broad benefits in part because restrictions in the scope of coverage often *increase* costs. If primary care is limited, for example, more people use hospital emergency rooms and wait longer to see a doctor. If there is no coverage of home health or hospice care, hospital stays are longer.

Making the nationally defined benefit more restrictive and leaving more services to coverage through supplemental insurance would not necessarily save money. Actually, it would perpetuate the adverse selection and cost-shifting widely practiced today. For the Federal government, the most significant result of a less generous benefit would be higher costs to supplement coverage for low and moderate-income people, and diminution of its ability to control costs.

The Health Security Act allows plans to adopt one of three cost-sharing arrangements. The range of cost-sharing is consistent with the types of health plans on the market today, including traditional fee-for-service, preferred provider organizations and health maintenance organizations.

Comprehensive benefits and uniform cost-sharing substantially reduce paperwork by minimizing ambiguities and eliminating the need for coordination of coverage. Those changes also eliminate complicated variations in deductibles, copayments, and stop-loss coverage.



COMPREHENSIVE BENEFIT PACKAGE: SUMMARY OF TITLE I, SUBTITLE B

The Health Security Act ensures coverage of the comprehensive benefit package described below by all qualified health plans offered to Americans and legal residents.

The benefit package does not itemize types or classes of providers. All health professionals licensed or otherwise authorized by a state to deliver health services may provide all medically necessary or appropriate services. No state may, through licensure requirements or other restrictions, limit the practice of any class of health professionals except as justified by the skill and training of such professional.

A conscience clause stipulates that providers and health facilities are not required to provide services that they object to on moral or religious grounds.

COVERAGE

The following services are covered if medically necessary or appropriate:

- Hospital services
- Health professional services
- Emergency and ambulatory medical and surgical services
- Clinical preventive services
- Mental illness and substance abuse services
- Family planning services and services for pregnant women
- Hospice care
- Home health care
- Extended care services
- Ambulance services
- Outpatient laboratory, radiology, and diagnostic services,
- Outpatient prescription drugs and biological
- Outpatient rehabilitation services

- Durable medical equipment and prosthetic and orthotic devices
- Dental care
- Vision care

Hospital services include inpatient and emergency care.

Health professional services are provided by doctors or other health professionals (e.g. nurses or physician assistants) who are legally authorized to provide the particular physician services in that state. Services include those provided in a home, office or other ambulatory care and institutional settings.

Emergency and ambulatory medical and surgical services include 24–hour–a–day emergency services, ambulatory medical and surgical services when furnished by a health facility that is not a hospital (e.g. birthing centers) that are legally authorized to provide the services in a particular state.

Clinical preventive services include age–appropriate immunizations, tests and clinician visits furnished in accordance with a specific periodicity schedule set forth in legislation; items and services for high risk populations (as defined by the National Health Board) when furnished in a manner consistent with a periodicity schedule set by the Board; and others immunizations, tests and clinician visits furnished based on standards established by the Board.

Mental illness and substance abuse services include inpatient and residential treatment, intensive nonresidential treatment, and outpatient services, including screening and assessment, diagnosis, medical management, psychotherapy, crisis services, collateral services and case management. Medical management, even for the severely ill, diagnosis, screening and assessment, and crisis services are not subject to annual day and visit limits.

By January 1, 2001, the Act replaces current insurance market strategies of annual day limits on inpatient, residential and intensive nonresidential treatment, psychotherapy and substance abuse counseling and relapse prevention with a managed benefit. In addition, higher copayments and coinsurance for psychotherapy and collateral services are reduced.

Until that time, the Act emphasizes a wide range of innovative treatment options, including case management, partial hospitalization, day treatment programs, and home–based and behavioral aide services including programs that are important to the treatment of seriously emotionally disturbed children. Providing coverage for this array of treatment options represents a new direction for the delivery of mental illness and substance abuse services and creates incentives for the development of needed capacity.

Health plans are encouraged to utilize the wide array of treatment options to provide individuals with a continuum of care -- that is both appropriate for an individual's needs and cost-effective -- through substitution of inpatient and residential days for treatment in other settings. Thirty days of inpatient and residential treatment may be reduced by one day for every two days of intensive nonresidential treatment or by one day for every four outpatient visits for psychotherapy or substance abuse counseling and relapse prevention.

Beyond the services covered through substitution, additional treatments are covered to provide ongoing and appropriate support. A maximum of ~~thirty~~ additional inpatient days are covered for particularly vulnerable individuals. A maximum of 60 additional days of intensive nonresidential treatment are available. Again without substitution, ~~thirty~~ visits of psychotherapy and collateral services are covered, and 30 visits in group therapy are covered for substance abuse counseling and relapse prevention for individuals who have received ~~other~~ treatment within 12 months.

Family planning and services for pregnant women include voluntary family planning services, contraceptive devices, and a wide range of services for pregnant women.

Hospice care services are modeled after those currently covered by Medicare.

Home care services are also modeled after those currently covered by Medicare are limited to services after illness or injury, and require re-evaluation at the end of each 60 day period.

Extended care services provided by a skilled nursing or rehabilitation facility are covered as an alternative to institutional care with an annual maximum of 100 days.

Ambulance services include ground transportation by ambulance or, when necessary, air or water transportation.

Outpatient laboratory, radiology, and diagnostic services for individuals who are not inpatients in a hospital, hospice, skilled nursing facility or rehabilitation facility are covered.

Outpatient prescription drug benefit includes both approved and off-label uses of FDA approved drugs and biologicals. The coverage of unapproved uses is based on the 1993 OBRA Medicare language which specifies that all unapproved uses for medically accepted conditions are covered that are specified in compendia or peer review literature.

Durable medical equipment and prosthetic and orthotic devices are covered, including accessories and supplies necessary for the repair, function and maintenance,

as well as fitting and training for use of such items. Coverage is limited to items or services that improve an individual's functional capacity or prevent further deterioration in function.

Vision care routine eye examinations and diagnosis and treatment of defects in vision are covered. Eyeglasses and contact lenses are covered for those under 18 years of age.

Dental care includes emergency treatment for adults and children as well as coverage for prevention and treatment of dental disease in children. In 2001, coverage for prevention and treatment of dental disease is expanded to cover adults. At that time, limited orthodontic services for children are also added.

Health education classes, including smoking cessation, nutrition counseling, stress management, support groups, physical training, or classes that are otherwise intended to encourage reduction of behavioral risk factors and promote healthy activities, may be offered at the discretion of the plan.

Investigational treatments may be covered at the discretion of a health plan; however, all routine care provided during a "qualified" investigational treatment (i.e., for which the effectiveness has not been proven and is part of a qualified research trial) is covered.

EXCLUSIONS

Any item or service that is not medically necessary or appropriate is excluded. In addition, the following items and services are specifically excluded:

- Custodial care other than that specified for hospice.
- Procedures performed solely for cosmetic indications and that are not the result of a congenital defect, accidental injury, disease, or medically necessary or appropriate surgery.
- Hearing aids.
- Eyeglasses and contact lenses for individuals 18 years of age and older.
- In-vitro fertilization services.
- Sex change surgery and related services.
- Private duty nursing.
- Personal comfort items except for hospice care.
- Dental procedures ~~not~~ specified in the benefit.

COST SHARING

Health plans adopt one of three models for cost sharing: lower cost sharing, higher

cost sharing and combination cost sharing:

Lower cost sharing:

- No co-payments for inpatient services.
- $10 co-payments for outpatient services.
- $5 co-payments for outpatient prescription drugs.
- $1500 individual/$3000 family maximum on out-of-pocket spending.
- Out-of-network items or services (through a point-of-service option) require payment of co-insurance at a level to be determined by the National Health Board but not less than 20 percent.

Higher cost sharing:

- 20 percent coinsurance.
- $200 individual/$400 family deductible on medical services.
- $250 deductible on prescription drugs.
- $50 deductible on dental services
- One-day deductible on inpatient mental health and substance abuse treatment.
- $1500 individual/$3000 family maximum on out-of-pocket spending.
- All deductibles apply to out-of-pocket maximum.

Combination cost sharing:

- Follows lower cost sharing model for providers in network.
- Follows higher cost sharing -- primarily 20 percent coinsurance -- for providers outside the network.

ROLE OF THE NATIONAL HEALTH BOARD

The National Health Board interprets and updates the nationally guaranteed comprehensive benefits package and ensures uniformity of coverage among all health plans. In addition, the Board:

- Defines services or items that are not medically necessary or appropriate.

- Accelerates expansion of benefits prior to 2001, but only if changes will not cause any regional alliance to exceed annual limits on the rate of growth of insurance premiums.

- Specifies compendia or medical literature for identification of medically accepted but unapproved uses of prescription drugs.

- Identifies authoritative texts that specify diagnostic criteria for mental disorders and

substance abuse disorders.

- Modifies the services and periodicity schedule for clinical preventive services.

- Defines high-risk populations for certain illnesses and diseases and specifies any additional clinical preventive services or items for which individuals included in high-risk categories are eligible without cost-sharing.

- Specifies life-threatening diseases, disorders, or other health conditions for the purpose of defining covered investigational treatments.

- Determines the amount of cost sharing that patients enrolled in plans that use lower cost sharing pay to exercise the point-of-service option.

II. THE NEW MARKET FOR HEALTH CARE

FEDERAL RESPONSIBILITIES

OVERVIEW

The Health Security Act builds on institutions that already exist, constructing a new framework around the private market for health coverage. It relies primarily on the power of competition to control rising health costs but backs it up with nationally established limits on the rate of growth in insurance premiums.

The approach adopted in the Health Security Act focuses on helping consumers obtain value for their money; it requires health plans to compete on both price and quality of service. It ensures that consumers have the option to choose among health plans and providers, taking concrete steps to bolster traditional fee-for-service medicine and preserve the option for patients to consult any physician.

The Health Security Act establishes essential protections at the national level, building the solid foundation for health security. Within that national framework of coverage, benefits, consumer protection and financing, however, states play a major role in organizing health services and adapting them to local circumstances. A state that prefers to adopt a single-payer system may do so.

To carry out the goals of health care reform, the federal government, states and alliances divide key responsibilities as follows:

Federal Government: Sets the basic framework for the system
• **Ensures universal coverage in a seamless system**
• **Defines guaranteed benefits package**
• **Determines caps on growth in insurance premiums**
• **Reforms insurance system**
• **Establishes quality measures**
States: Implement health care reform within federal framework
• **Establish alliance(s)**
• **Certify health plans**
• **Monitor quality and availability of care**
• **Implement insurance reform**
Alliances: Serve as purchasing agents for employers and consumers
• **Solicit bids from competing health plans**
• **Distribute information to consumers**
• **Collect premiums and pay health plans**
• **Administer discounts to families and small business**

I think this should follow the order of the bill. This emphasize federal too much. (I)

FEDERAL RESPONSIBILITIES: SUMMARY OF TITLE I, SUBTITLE F

NATIONAL HEALTH BOARD

The Health Security Act creates a National Health Board that sets critical standards for the private market for health coverage. The board does not duplicate the work of existing federal agencies but is ultimately responsible for fulfilling the national commitments to security for all Americans.

A new executive branch agency, the National Health Board, consists of seven members appointed by the President and with the advice and consent of the Senate.

The President designates one member as chairman, who serves a term concurrent with that of the President and serves at the pleasure of the President. The chairman may serve a maximum of three terms. The other members serve staggered four-year terms but may be reappointed for one additional term.

QUALIFICATIONS

Each member of the National Health Board is a citizen of the United States. During their terms, Board members serve as employees of the federal government and hold no other paid position.

They may not have a pecuniary interest in or hold an official relation to any health care plan, health care provider, insurance company, pharmaceutical company, medical equipment company or other affected industry. After leaving office, former Board members are subject to appropriate post-employment restrictions.

Members are selected on the basis of their experience and expertise.

RESPONSIBILITIES

The National Health Board undertakes the following tasks:

- Ensures access to guaranteed health services for all eligible individuals by establishing requirements for participating states and initially approving state plans to implement reform, in addition to providing technical assistance to states.

- Interprets and updates the nationally guaranteed benefit package and recommends to the President and Congress adjustments to reflect changes in technology, health needs and methods of service delivery.

- Oversees cost containment requirements and certifies compliance.

- Establishes and oversees a performance-based system of quality management and improvement.

- Oversees the development of the national health information system.

OPERATION

The National Health Board appoints an executive director, as well as additional officers and employees, subject to civil service rules. The Board may establish advisory committees and contract with other government departments and organizations to conduct research or other tasks related to its work. It has access to all relevant information available from federal departments and agencies and coordinates its activities with other federal agencies.

The Department of Health and Human Services continues to administer existing programs, such as Medicaid, Medicare and the Public Health Service, and implements aspects of health reform not assigned to the National Health Board or other departments.

IMPLEMENTATION OF REFORM

Initially, the Board's primary role revolves around reviewing and approving state plans for implementation of reform. The National Health Board assumes responsibility to:

- Establish, in consultation with states, minimum capital requirements for health plans.

- Set requirements for guaranty funds, in consultation with states.

- Define requirements for health plan grievance procedures.

- Establish factors used to translate the actuarial value of the comprehensive benefit package for an individual into accurate premiums for other family categories.

- Develop a methodology for risk adjustment in payments to health plans, taking into account such factors as demographic characteristics, health status, area of residence, socio-economic status and the proportion of participants who receive AFDC or SSI payments.

If the Board determines that an adequate system of prospective risk adjustment cannot be developed before implementation of reform, the Board will require states to establish a reinsurance program to cover all or part of the cost of care for high-risk patients.

No later than July 1, 1995, the Board issues regulations describing requirements for state health care systems; the Board may not approve a state plan to begin prior to 1996. Once submitted, the Board approves a state plan unless the state is not meeting requirements defined for participating states.

If a state fails to submit a plan, to implement reform, or to meet established requirements -- and if its actions are sufficient to substantially jeopardize access to guaranteed coverage for its residents -- its failure triggers a series of progressively more serious steps to fulfill federal commitments. In such a case, the Federal Government may:

- Order existing regional alliances or health plans to comply with national standards.
- Reduce the amount of payments for academic health centers, medical education, research, public health programs and payments to hospitals serving vulnerable populations until the state takes appropriate action.
- Establish and operate alliances to ensure coverage in a financially stable system.

A state may apply at any time for approval to assume operation of federally administered alliances.

FEDERAL SUPPORT FOR STATE IMPLEMENTATION

Within 90 days of enactment, $50 million in annual federal appropriations for FY-1995 and FY-1996 is distributed among the states to support planning for implementation of health reform. Upon enactment of enabling legislation, states receive federal matching grants to assist in the development of regional alliances. ~~Appropriations~~ totaling $313 million for FY-1996, $625 million for FY-1997 and $313 million for FY-1998.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Except as specifically provided, the Secretary of the Department of Health and Human Services administers and implements the Health Security Act.

The Secretary, in consultation with the Secretary of Labor and the Secretary of the Treasury, establishes standards for regional health alliances related to the management of finances, maintenance of records, accounting and auditing procedures.

The Secretary performs periodic financial and other audits of regional alliances, including assuring the enrollment of eligible individuals.

The Secretary appoints a 13–member Advisory Council on Breakthrough Drugs that examines and publishes its evaluations of prices for new prescription drugs.

RESPONSIBILITIES OF SECRETARY OF LABOR

In general, the Secretary of Labor is responsible for the enforcement of requirements for employers to contribute to paying for health coverage and for monitoring corporate health alliances.

STATE RESPONSIBILITIES

OVERVIEW

Reflecting the broad diversity of the United States, the Health Security Act allows each state to tailor health reform to its unique needs and characteristics.

States exercise flexibility in the design of regional purchasing alliances. The Health Security Act sets ~~essential~~ measures for health plans related to quality and access. ~~States apply the standards.~~

States certify health plans, much as they license insurance companies today in many states. States establish criteria for evaluating financial stability and capacity to deliver the guaranteed benefits, as well as critical standards such as prohibitions against discrimination.

In ~~the case of~~ areas where no health plan ~~forms~~, the state assures that at least one health plan is available to cover every eligible individual.

If a state were to fail to carry out its responsibility -- jeopardizing the national guarantee of comprehensive coverage for all -- the federal government would ensure that its commitments are fulfilled. However, any steps undertaken to meet those commitments would be pursued with the intention that the state resume its proper role as rapidly as possible.

STATE RESPONSIBILITIES: SUMMARY OF TITLE I, SUBTITLE C

Beginning in 1996 but no later than January 1, 1998, each state develops a plan to implement national health care reform and submits it to the National Health Board. The plan describes how the state intends to perform each of the following functions:

- Establish one or more regional alliances.
- Certify health plans.
- Assure the financial solvency of plans.
- Designate an agency or official charged with coordinating state responsibilities.
- Amend state laws related to medical care under workers' compensation and automobile insurance.
- Carry out other responsibilities described in the Act.

ESTABLISHMENT OF REGIONAL HEALTH ALLIANCES

No later than January 1, 1998, each state establishes one or more regional health alliances and designates the geographic area in which each alliance provides health coverage.

Each alliance encompasses a population large enough so that it has adequate market share to negotiate effectively with health plans. States may establish one, and only one, regional alliance in each area.

In establishing boundaries for health alliances, states may not discriminate on the basis of or take into account race, ethnicity, language, religion, national origin, socio-economic status or perceived health status. All of a primary metropolitan statistical area within a state's boundaries must be included in the same alliance.

An alliance may not cross state lines, but adjacent states may require adjacent alliances to coordinate ~~operations, including~~ adoption ~~of~~ joint operating rules, contracting with health plans, and negotiation ~~of~~ fee schedules for health providers. A state may also require its regional alliances to coordinate operations.

States assure that revenue owed to alliances in the state are collected and paid.

QUALIFICATION OF HEALTH PLANS

States qualify health plans (other than self-funded health plans) to participate in both regional and corporate alliances, and they monitor compliance. States also assume responsibility for:

- Ensuring that each eligible family has access to a choice of health plans, including to the extent possible ~~to the extent possible~~ adequate access ~~(to the maximum extent practicable)~~ to a plan whose premium is at or below the weighted-average premium in the area.

  To fulfill this requirement, a state may require health plans to serve an entire alliance area or selected areas.

- Ensuring that families and businesses eligible for discounts on health plans' premiums receive them.

- Ensuring that health plans provide access to academic health centers and essential community providers.

- Creating incentives for health plans to enroll members of disadvantaged groups.

- Providing appropriate extra services, such as outreach to encourage enrollment, transportation and translation services for disadvantaged groups.

- Coordinating health services provided under workers' compensation and automobile insurance.

- Implementing a reinsurance system for to protect the financial stability of all health plans.

- Seeing that health plans adopt standards for supplemental insurance and use uniform, nationally established cost-sharing arrangements.

States may not discriminate against health plans based on their domicile. They also may not regulate premium rates charged by health plans, except when necessary to meet budget requirements or to ensure that plans meet solvency requirements.

SOLVENCY AND FISCAL OVERSIGHT

Each state establishes capital standards for health plans that meet minimum Federal requirements. Each state defines financial reporting and auditing requirements.

Each state ensures that a guaranty fund protects the financial interests of health care providers and consumers in the case of failure of a health plan.

FAILURE OF A HEALTH PLAN

In the case of a health plan failure, the state ensures continuity of coverage for consumers and may require all health plans to pay an assessment (not to exceed two percent of premiums) to cover any outstanding claims against the failed plan.

If a health plan fails, providers are required to continue caring for patients until they are enrolled in a new plan. The state guaranty fund pays health providers for services delivered in such a case, and providers may not seek payment for those services from patients.

ADDITIONAL BENEFITS

Any state may provide health benefits in addition to the nationally guaranteed comprehensive package. However, states may not pay for expanded benefits with revenues raised under the Health Security Act.

SINGLE-PAYER OPTION

A state may establish a single-payer system rather than an alliance system; a state also may establish a single-payer system that serves only a portion of the state.

A single-payer system is one in which the state or its designated agency makes all payments to health providers with no intermediaries, health plans or other entities assuming financial risk. However, providers may assume risk by accepting capitated payments based on the number of individuals enrolled.

The National Health Board is required to approve state applications to implement a single-payer system if the state plan ~~meets~~ national requirements, limits the growth of insurance premiums and delivers the comprehensive benefit package. and meets other

The single-payer system may provide for the enrollment of Medicare beneficiaries if the state meets requirements for the integration of Medicare that protect beneficiaries and the Federal Treasury. States must request a waiver from the Secretary of the Department of Health and Human Services to integrate ~~networks~~ Medicare

~~States operating a single-payer system operate through a single statewide alliance system and meet basic requirements established for participating states.~~

A state finances a single-payer system using, at least in part, a payroll-based system that requires employees to pay at least the amount they would have paid under the alliance system. Federal funds that would be available for discounts under an alliance system in a state continue to be available if the state elects to establish a single-payer system.

States have the option of integrating large employers including those eligible to form corporate alliances.

States operating a single-payer system for parts of the state comply with rules applicable to statewide single-payer systems

States that establish single-payer systems must meet basic requirements for participating states.

HEALTH ALLIANCES

OVERVIEW

An essential strategy of the Health Security Act is to extend to all Americans and their employers the advantages that large employers and their workers already bring to negotiations with health plans and providers.

Under the Health Security Act, each state creates one or more health alliances that organize a choice of health plans, negotiate premiums and enroll individuals much as major national corporations do for their employees.

Alliances are ~~conceived as~~ purchasers of coverage, not ~~as~~ regulatory agencies. States continue their traditional roles as regulators of insurance, and licensor of health institutions and providers. ~~Health alliances organize a choice of health plans for consumers, negotiate community rated premiums, establish contracts and manage enrollment.~~

Under the Health Security Act, regional alliances serve workers employed by firms with less than 5,000 employees, as well as self-employed individuals ~~and their families~~, part-time workers and those who are not employed.

The largest national corporations -- those employing 5,000 workers or more -- have the option to operate their own corporate alliances or to join regional alliances. With the exception of individuals eligible for certain other programs, such as Medicare ~~and the Indian Health Service~~, every American and legal resident purchases health coverage through one type of alliance or the other.

~~Although individual consumers might not have much direct contact with the alliance, it contributes to several important goals of reform:~~

- ~~Structuring a market in which health plans compete on price and service rather than risk selection.~~
- Allowing individual consumers, rather than their employers, to choose the health plan they prefer.
- Assisting consumers in choosing among competing health plans by providing comparative information on price, quality of care, access and satisfaction.
- Enabling consumers to retain the savings from enrolling in less expensive health plans and, conversely, to bear the cost of enrolling in more expensive plans.

This doesn't really seem like the job of the alliance

- Providing a mechanism for employers to share premium responsibility.
- Consolidating the buying power of small and medium-sized employers and their employees into a single purchaser of health coverage to spread risk, reduce administrative costs, expand choice and increase market leverage.
- Serving as the mechanism for keeping the growth of spending within targeted limits.

These functions are

While the framework of regional and corporate health alliances represents a national innovation, its basic approach is increasingly common among major American corporations and in some communities. In addition, a number of large employers have created incentives for cost-conscious choice, as the Health Security Act does.

This needs to be stronger. Explain why we need alliances. Why this structure works.

HEALTH ALLIANCES: SUMMARY OF TITLE I, SUBTITLE D

Regional health purchasing alliances are non-profit organizations, independent state agencies or agencies of states. They are operated by a board of directors composed of consumers and employers.

Board members may not include individuals or their families who own or earn their living through health care institutions or organizations.

Each regional alliance also forms a provider advisory board made up of doctors, nurses, hospital administrators and others who participate in its health plans.

Regional health alliances contract with any-willing state-certified health plan to deliver the comprehensive national benefit package. A regional alliance may decline to contract with a health plan only if:

- Its proposed premium exceeds 120 percent of the alliance's weighted-average premium.
- The plan failed to comply with earlier contracts, including failing to offer full coverage in its service area.

Each alliance offers a choice of health plans including at least one fee-for-service plan. Each regional alliance establishes a rate schedule for fee-for-service plans and out of network services under PPOs and point-of-service plans under HMOs through negotiations with providers.

Health alliances may not discriminate against health plans on the basis of race, gender, ethnicity, religion, mix of health professionals, location of the plan's headquarters or organizational structure.

ENROLLMENT

Regional alliances assure that each eligible individual residing in their area enrolls in a health plan. Each regional alliance holds an annual open enrollment period and establishes procedures for consumers to resign from health plans for good cause at any time.

Alliances maintain a point-of-service enrollment mechanism for individuals who fail to enroll until they seek care. Alliances require payment of twice the amount of the individual or family share of the premium from individuals who fail to enroll, unless the individual demonstrates good cause.

Alliances also establish a procedure for enrollment decisions in cases in which more consumers wish to join a health plan than its capacity allows.

CONSUMER INFORMATION AND MARKETING

Regional alliances provide easily understood and useful information that assists consumers in evaluating and comparing health plans. Alliances review and approve marketing materials.

They also establish an ombudsman to deal with consumer complaints and problems.

AREAS WITH INADEQUATE HEALTH SERVICES

To ensure that health plans are available in all areas served by the alliance, alliances may adjust payments or use other financial incentives to encourage expansion of health plans. Alliances may help organize providers and assist with technical support to establish a new health plan. Regional alliances may not bear insurance risk.

COORDINATION AMONG ALLIANCES

The alliance in which a family is enrolled in the month of December is responsible for the collection of premiums for the entire year, regardless of whether the family moves. Families with multiple employers choose one that assumes responsibility to deduct premiums from wages.

For full-time students living away from home, the alliance in which the parent is enrolled pays the student's alliance where the student attends school an appropriate portion of the family premium.

In the case of couples in which one spouse is eligible for regional alliance coverage, the regional alliance pays the corporate alliance the employer share of the premium.

ESTABLISHING PREMIUMS

Regional alliances negotiate with health plans a community-rated premium calculated on a per person basis for providing the nationally guaranteed comprehensive benefit package.

Based on premium bids from health plans, regional alliances publish the "family share" of the premium -- 20 percent of the total -- for each category of family policy: individual, couple, two-parent family and single-parent family. (see financing section)

Alliances charge the appropriate family share to individuals and families, for the health plans they choose. The among a family pays depends on the premium for the plan less the employer contribution and any discounts to which a family is entitled. They also compute the employer premium for each category of family enrollment and collect payments from employers.

Alliances notify families of the amount they owe for premiums and may require payroll deduction. Failure to pay premiums does not result in loss of coverage, although alliances use credit and collection procedures to pursue late payments.

The Secretary of Labor promulgates rules for employers to follow in withholding premium payments from wages. The Secretary of the Department of Health and Human Services promulgates rules for payments by families that do not include employees of firms.

PAYMENTS TO HEALTH PLANS

Alliances calculate the amount they pay health plans based on a rate per person adjusted to account for differences in the level of risk among participants in each plan.

Regional alliances contribute 1.5 percent of premiums to a national fund to support academic health centers and graduate medical education. In addition, they may retain an amount not to exceed 2.5 percent of premiums as an allowance for administrative costs.

APPLICATIONS FOR DISCOUNTS ON PREMIUMS

Individuals apply for discounts on cost-sharing and health plan premiums. Regional alliances distribute applications for discounts to consumers, to banks, to employers and to public agencies. Applications may be filed by mail or in person and submitted to the alliance at any time. Applications require a declaration of income, which is verified at the end of the year.

Individuals who knowingly misrepresent their incomes are not eligible for future discounts.

YEAR-END RECONCILIATION

Families receiving premium discounts file annual income reconciliation statements and are entitled to a rebate for excess payments. Those that paid too little make up the difference. Families that fail to file reconciliation forms are disqualified from receiving future discounts.

REDUCTIONS IN COST SHARING

Families receiving Aid to Families with Dependent Children or Supplemental Security Income as well as those with adjusted incomes below 150 percent of the federal poverty level are eligible for discounts on cost sharing. However, discounts for cost-sharing are only available in areas in which health plans that use low-cost sharing and combination cost-sharing (with premiums below the weighted average in the alliance) have insufficient capacity to accommodate all families that qualify for reduced cost-sharing.

For families that receive AFDC or SSI, additional reductions bring cost sharing down to 20 percent of the amount otherwise required under a low cost-sharing plan (e.g. $2 per visit rather than $10 per visit).

EMPLOYER RESPONSIBILITIES

Employers manage payments for health premiums, including withholding employees' payments from wages. At the end of each year, employers provide workers with a statement showing the total amount and destination of payments for health coverage made on the worker's behalf.

Employers also reconcile and adjust their premium payments to alliances at the end of the year, rolling over debits or credits to the following year.

No employer may discriminate against an employee on the basis of family status or category of family enrollment for health coverage. Employers also may not discriminate in the wages or compensation paid, or other terms or conditions of employment, based on the employee's choice of health plan.

NEW EMPLOYEES

When an individual is hired, the employer obtains basic information related to the individual's alliance area, category of family enrollment and health plan. The employer forwards that information to the appropriate regional alliance within 30 days.

VOLUNTARY EMPLOYER CONTRIBUTIONS

If an employer chooses to make a voluntary premium payment beyond the amount required, it must treat all employees similarly and provide for rebates for employees who choose lower cost health plans.

Any voluntary contribution must be provided to all employees if it is provided by an employer, and the dollar amount provided may vary only by alliance area and class of enrollment (i.e. individual, couple only, single parent, and dual parent).

A voluntary employer contribution may not vary according to the health plan an employee selects. If an employee selects a health plan that costs the employee less than the employer's voluntary contribution, then the employee retains the full savings (which count as taxable income).

CORPORATE ALLIANCES

OVERVIEW

The Health Security Act recognizes the innovative role that America's largest employers have played in developing and supporting new approaches to the delivery of health care and the control of costs.

To preserve that leadership, the Health Security Act provides that firms employing more than 5000 workers, Taft-Hartley plans and rural cooperatives of the same size may continue to cover their workers by organizing corporate alliances. The United States Postal Service also may operate as a corporate alliance.

Corporate alliances provide health benefits either through a self-funded employee benefit plan or through contracts with qualified health plans. They operate under much the same rules regarding quality, access and choice as regional alliances.

Reversing the trend toward limiting employee choice as a means to control costs, however, the Health Security Act requires each corporate alliance to contract with at least one fee-for-service health plan and to offer a choice among at least two additional health plans.

Under the Health Security Act, limiting choice will cease to be one of the primary tools in the struggle to control rising costs. In its place, the Health Security Act creates new incentives for cost-conscious choice on the part of consumers and providers, backed up by limits on the rate of growth of health insurance premiums.

The Health Security Act adapts the Employee Retirement Income Security Act of 1974 (ERISA) to complement national health reform, modifying provisions to enforce the shared responsibility of employers and employees in purchasing health coverage.

New provisions of ERISA establish fiduciary and enforcement requirements for employers and others sponsoring corporate alliances. The provisions

- Ensure that everyone enrolled in corporate health alliances obtains coverage for the nationally guaranteed benefit package or more expansive benefit.
- Establish fiduciary requirements for employers, sponsors of health plans and fiduciaries.
- Set requirements related to notification and information made available to employees.
- Ensure compliance with national standards with respect to uniform claims forms, data reporting, electronic billing and other areas.

- Apply grievance and benefit dispute procedures to self-funded health benefit plans.

- Establish financial reporting requirements for self-funded health benefit plans and for corporate alliances.

- Set financial reserve requirements.

CORPORATE ALLIANCES: SUMMARY OF TITLE 1, SUBTITLE D

Corporate alliances follow similar rules to regional alliances in regard to enrollment and offer a choice of health plans.

Corporate alliances negotiate premiums with health plans and fund their contributions through self-insurance or insurance.

Corporate alliance self-insured health plans meet minimum reserve requirements.

Health plans may terminate contracts with corporate alliances that fail to pay premiums. In such a case, the corporate alliance is responsible for promptly enrolling participants in another plan. If the sponsor of a corporate alliance becomes bankrupt or cease to fund its health plan, participants are promptly enrolled in regional alliance health plans.

Corporate alliances control the rate of growth in health insurance premiums.

A corporate alliance terminates once the number of full-time employees or active participants falls below 4,800 or if the corporate alliance chooses to cease operation.

COMMUNITY-RATED PREMIUMS

Corporate alliances may offer either a self-insured health plan or a state-certified health plan, or both. Corporate alliances offer all employers a choice of at least three health plans, one of which must be a fee-for-service is offered to all enrollees.

Although corporate alliances may pay health plans experience-rated premiums, premiums charged to employees are based on community rating.

In order to replace the discounts available to low-income families in regional alliances, corporate alliances make additional premium contributions on behalf of low-wage employees. For employees whose families earn less than $15,000 for full-time work, corporate alliance employers pay the greater of 95 percent of the premium for the least-

expensive plan available through the corporate alliance using lower or combination cost-sharing arrangements or 80 percent of the weighted average premium.

Regional alliance rules prohibiting redlining and the division of metropolitan statistical areas for the purpose of calculating premiums also apply to corporate alliances.

QUALITY AND INFORMATION

Corporate alliances implement quality management programs and provide information related to quality, access and price just as regional alliance do. They provide annual performance reports on health plans and comparative information to consumers.

COORDINATION OF PAYMENTS

Corporate alliances make payments to regional or other corporate alliances in cases in which families eligible for coverage through two alliances enroll in another.

PROVISION FOR FAILURE OF A CORPORATE ALLIANCE

If the Secretary of Labor determines that a self-insured corporate alliance is unable to provide guaranteed health benefits, the Secretary applies to the United States District Court for appointment as trustee to manage the alliance.

To pay for services in the event of a failed corporate alliances, the Secretary establishes a Corporate Alliance Health Plan Insolvency Fund paid for from corporate alliance premiums.

COMPETING HEALTH PLANS

OVERVIEW

The Health Security Act ensures choice of health plans for consumers, guaranteeing coverage and access to the nationally guaranteed comprehensive package of benefits.

Competing health plans already exist: Over the last two decades health maintenance organizations have gained an increasing share of the health care market; new models, such as preferred provider networks and other forms of managed care, are evolving rapidly. Along with traditional fee-for-service plans, each approach offers different advantages and appeals to different consumers.

The concept that underlies the Health Security Act rests on a few key points: competing health plans each face the same problem of determining how many and what types of physicians, hospitals and other providers they require. Health plans that use resources most effectively and take good care of their patients will attract more patients and earn more revenue. Health plans that squander resources through inefficiency or provide bad service will adapt to the new competitive environment -- or lose out.

By empowering consumers to choose among health plans, the Health Security Act creates incentives for the competitive market to work to consumers' advantage -- rather than to the advantage of insurance companies, health are providers or employers -- by producing better care, better services, and better prices.

Information and an organized market are key to empowering consumers, however. The failure of the traditional health insurance market stems from consumers' inability to exercise their usual savy judgement as prudent buyers.

The reform proposed in Health Security Act represents a blueprint for ensuring that American consumers have the opportunity -- and the information -- to act as prudent buyers and to have as broad a range of choice among competing health plans as possible.

The Health Security Act creates new incentives for health plans to compete on quality, service and price. It promotes the delivery of effective care and rewards plans that accomplish those goals.

Over the last two decade health maintenance organizations, managed care plans, preferred provider organizations and other new models have joined traditional fee-for-service arrangements in the market for health care. Under reform, these plans will continue but operate in an environment of increase accountability lacking in the current system.

By empowering consumers to choose among health plans the Health Security Act creates incentives for competition to work to consumers' advantage -- rather than to the advantage of insurance companies, health providers or employers.

RISK ADJUSTMENT

Effective, on-going risk adjustment is one of the safety valves built into the Health Security Act, ensuring that health plans compete on efficiency and effective care, not on their ability to attract healthier patients.

Under the Health Security Act, health plans charge the same premiums for all participants who purchase the same type of family policy, regardless of age, health, disability, gender or other personal characteristics.

However, alliances pay health plans an amount for each participant's care, that is risk-adjusted to account for health characteristics of individuals who enroll.

Through risk adjustment, payments from alliances compensate plans that enroll a higher-risk population. Adjusters that compensate for cost differences by age, for example, reduce economic incentives for plans to discriminate according to age. As reform is implemented, alliances expand their capacity to compensate for other factors, eliminating economic disadvantages from enrolling various groups.

For Medicaid cash-assistance recipients (AFDC, SSI), regional alliances compute an annual "blended plan payment amount" for each eligible person, which takes into account factors such as age, gender and health status.

TYPES OF HEALTH PLANS

Health reform protects the right of doctors and other providers to participate in multiple health plans. Likewise, by requiring all health plans to offer a point-of-service option, reform expands the ability of patients to consult physicians and other providers outside the network of a plan, although exercising that option will require an additional payment.

Inherent in the Health Security Act is the conviction that better organized and more efficient health plans will prosper in the long run -- and a commitment to opening up the range of possibilities for entries in that competition. It opens the way for groups of local doctors and hospitals to form networks of providers. By fostering the emergence of community-oriented health plans, reform allows professionally centered health plans to position themselves to compete with insurance companies.

To protect consumers, the Health Security Act also establishes new rules for supplemental benefit policies. Supplemental policies may cover all or some portion of benefits not included in the comprehensive benefits. A policy covering cost sharing might pay a portion of co-insurance required by a health plan. Both are allowed.

To achieve greater simplicity and efficiency, health services covered under workers compensation and automobile insurance are provided through the health plans that all individuals and their employers purchase.

To obtain state certification, health plans demonstrate their ability to provide or arrange for medical benefits required for work-related injuries and illnesses and for automobile injuries, including rehabilitation and long-term care services. Financing continues to be handled separately.

HEALTH PLANS: SUMMARY OF TITLE I, SUBTITLE E

Competing health plans provide services guaranteed in the comprehensive benefit package through contracts with regional and corporate alliances. Only state-certified health plans may provide health benefits through regional alliances.

Health plans must accept every eligible person enrolled by an alliance regardless of individual characteristics, health status, anticipated need for health care, occupation or affiliation with any person or entity (except affiliation with a corporate alliance).

With the approval of the state, health plans may limit enrollment because of the plan's capacity to deliver services or to maintain financial stability. Plans may not:

- Terminate, restrict or limit coverage for any reason, including non-payment of premiums.
- Cancel coverage for any participant until the individual is enrolled in another plan.
- Exclude coverage of an individual because of medical conditions.
- Impose waiting periods before coverage begins.
- Impose a rider that serves to exclude certain individuals.

A health plan may not engage in any activity, including the designation of a service area, that has the effect of discriminating on the basis of race, national origin, gender, income, health status or anticipated need for health services.

Similarly, in selecting network providers or establishing terms and conditions for membership, a health plan may not engage in any practice that has the effect of discriminating against a provider on the basis of race, national origin, gender, income, health status or anticipated need for health services.

COMMUNITY RATING

Health plans use community rating to establish premiums within a regional alliance.

INFORMATION

Health plans submit marketing materials for approval by alliances. They provide to the alliance and make available to consumers and health care professionals information concerning:

- Premiums and required cost sharing.
- Qualifications and availability of providers.
- Procedures used to control utilization of services and expenditures.
- Procedures for assuring and improving the quality of care.
- Rights and responsibilities of consumers and patients.
- Information on the number of consumers who leave the plan.

Health plans are responsible for the accuracy of information and may forfeit state qualification if information is inaccurate. Health plans also provide consumers with information about advance directives.

GRIEVANCE PROCEDURES

Health plans establish grievance procedures for resolving disputes over the delivery of care and coverage. Consumers also may seek assistance from the alliance ombudsman to resolve complaints.

ARRANGEMENTS WITH PROVIDERS

Health plans enter into agreements with health care providers to deliver services in the comprehensive national benefit. They verify the credentials and licenses of participating providers and oversee the quality of care they provide.

Health plans cover emergency and urgent care services without regard to whether the provider has a contractual arrangement. Payments for emergency and urgent care outside the plan's service area are paid according to the alliance fee schedule where care is provided.

A provider may not charge or collect from a patient a fee in excess of the fee schedule adopted by an alliance (or determined under contractual agreement) for services provided under the nationally guaranteed benefits. Similarly, a provider may not directly bill a patient for amounts payable by the health plan.

If a provider voluntarily agrees to reduce the amount charged to a patient, the health plan reduces payments to the provider by the same proportion.

In the event that premiums exceed allowable rates of increase, health plan's agreements with providers allow for the reduction of payments to meet premium targets.

State laws may not be applied against health plans that are not fee-for-service plans if they have the effect of prohibiting plans from:

- Limiting the number and type of health providers who participate in the plan.
- Requiring participants to obtain health services other than emergency services from providers authorized by the plan, unless the patient is exercising a point-of-service option.
- Requiring participants to obtain referrals for specialty treatment.
- Establishing different payment rates for participating health providers and for providers outside the network.

- Creating incentives to encourage the use of participating providers.

- Using single-source suppliers for pharmacy, medical equipment and other health products and services.

In addition, state laws related to corporate practice of medicine and to provider ownership do not apply to arrangements between integrated health plans and participating providers.

FINANCIAL SOLVENCY

Health plans must meet or exceed state minimum capital requirements, participate in a state guaranty fund and meet other requirements relating to fiscal soundness established by the state.

POINT-OF-SERVICE OPTION AND COST SHARING

Health plans establish cost sharing arrangements that cover out-of-network items and services as well as deductibles and coinsurance for network services.

Plans that adopt the low cost-sharing schedule apply it to all items and services in the comprehensive benefit package. Low cost-sharing plans also offer a point-of-service option that allows participants the opportunity to obtain services outside the network. Those plans may charge an alternative premium to cover the point-of-service option.

In providing the comprehensive benefit, low cost-sharing health plans include in their payments to providers additional reimbursement as necessary to reflect any reductions in cost sharing.

QUALITY MANAGEMENT AND REPORTING OF INFORMATION

Health plans comply with quality management requirements as well as with requirements for information reporting and the protection of patient confidentiality.

REINSURANCE

Health plans must participate in state reinsurance systems.

SUPPLEMENTAL INSURANCE

They may offer supplemental coverage for additional benefits and for cost sharing. Health plans may not offer supplemental policies that duplicate coverage under either the comprehensive benefit package or the Medicare program. Supplemental insurance also may not cover required copayments.

Health plans that offer supplemental policies must accept all applicants for enrollment, subject to capacity limitations. (This requirement does not apply to supplemental policies offered on the basis of an individual's employment or membership in a fraternal, religious, professional or other organization.)

Health plans may offer policies that cover cost sharing only to participants in that plan and only if the policy is offered to all participants at the same price. All plans must offer a policy to cover cost sharing, but such a policy may not cover copayments under a low or combination cost sharing plan. Rates take into account anticipated increases in utilization resulting from the availability of supplemental coverage.

The ratio of premiums collected for supplemental policies to payments returned to consumers must be 90 percent or better. Supplemental policies are offered only during annual open enrollment periods and provide a choice between standard and maximum coverage.

States may not certify health plans that offer cost sharing coverage if they fail to meet these requirements. Supplemental plans offered by the Federal Employee Health Benefits Program are exempt from this requirement.

III. FINANCING AND CONTROLLING COSTS

FINANCING AND CONTROLLING COSTS

OVERVIEW

The Health Security Act asks American employers, their employees and all Americans to assume responsibility for purchasing health coverage. Joint responsibility shared between employers and employees forms the cornerstone of health security, building on the existing private market that already serves 90 percent of Americans who have health insurance.

By requiring participation in a reformed health insurance market, the Health Security Act extends and solidifies the foundation of employer-sponsored health coverage. Carefully designed safeguards and limits strengthen it, adding an extra layer of protection for employers, families, workers and American taxpayers.

The discounts that undergird the premium-based finance system require an annual investment by the Federal Government of $21 billion in 1994 dollars. That amount grows to average $32 billion-a-year, or $160 billion over five years through the year 2000. It includes projections for inflation and a substantial cushion -- 15 percent of the total -- against uncertainty.

The commitment for the Federal Government to fund discounts available is limited to those budgeted amounts. It is not open-ended, in order to protect the federal budget and American taxpayers from any unlimited financial obligation.

States, too, gain financial stability and relief from the relentless escalation in the cost of Medicaid coverage for health care. Those rapidly rising costs have strained many state budgets. With implementation of reform, states maintain current levels of financing for health care provided under Medicaid, but are protected from uncontrolled increases in future payments. Bringing those expenditures under control ultimately will free state resources for other public purposes.

Discounts provided to individuals and families based on income extend to every American the same assurance that business receives -- that the responsibility to purchase health coverage will prove manageable. Although discounts benefit low-income families, they also protect working families of all income levels during periods of crisis, such as unemployment and divorce.

Because the Health Security Act offers comprehensive reform, the cost of providing coverage will decline for many employers:

- By extending universal coverage, reform eliminates approximately $25 billion in uncompensated care charged to private insurance premiums each year.

- Employers share responsibility for family coverage, reducing costs for those firms that currently pay the entire cost of family policies.

- Employers that purchase coverage through regional alliances pay community rates, eliminating the financial threat that serious illness in one worker's family could drive the cost of health coverage out of reach for others.

- Under the alliance system, the employer share of the cost of health coverage is based on average premiums in the area. As competition among health plans -- backed up by the safety net of national caps on the rate of increase in insurance premiums -- brings the rate of growth under control, the proportion of total resources devoted to health care will decline throughout the business sector.

CAPS ON INSURANCE PREMIUM GROWTH

While ample evidence supports the conviction that market competition will control the rate of growth in health care spending, the Health Security Act adds a final layer of protection in the form of enforceable caps on the rate of growth in insurance premiums.

Building on existing authority in many states to regulate insurance-premium increases, enforceable caps serve as a backstop -- or emergency brake -- ensuring that the critical goal of reducing rising costs is met. Caps serve to:

- Assure employers and consumers that health premiums will not rise faster than inflation. Because every American and every employer will participate in the health coverage system, the government must assume responsibility to set reliable boundaries on the cost of participation.

- Improve discipline in the market.

Enforceable premium caps establish clear, predictable expectations for health plans and providers. As long as competitive forces rein in the growth of health care costs, enforceable caps will not take effect. When premium increases exceed allowed rates, limits are imposed.

Establishing limits on the rate of premium increases does not mean that America will spend less on health care. Guaranteeing coverage will increase total national expenditures, and premium caps apply only to spending for the nationally guaranteed, comprehensive benefits, not to other health care services, such as nursing home care.

The Health Security Act pursues an aggressive strategy for cost containment during the first five years under reform, gradually pulling the rate of growth down to the rate of inflation. After five years, it broadens the range of considerations in establishing growth-rate targets to include the aging of the population and other factors.

The Health Security Act represents an aggressive but achievable cost-containment strategy -- one that is enforceable. It also represents a relatively simple design. Focusing caps on insurance premiums -- rather than on spending in each sector of the health care industry -- allows for less costly and less onerous administration: Alliances will reduce payments to health plans with excessive premium increases prospectively, by lowering the premium bid. That approach also ensures that the impact of premium caps reverberates back to providers, rather than to consumers.

A special provision that calls for returning excess premium payments to all consumers enrolled in an alliance -- rather than only to those enrolled in the plan -- creates strong incentives for health plans to act before the alliance acts by voluntarily lowering premiums in plans to align them with growth targets.

PREMIUM-BASED FINANCING: SUMMARY OF TITLE VI

Under the Health Security Act, the purchase of health coverage revolves around two shares: the individual or family share and the employer share. Each individual or family obtains coverage for one of four categories of family enrollment:

- An individual policy.
- A policy covering a married couple.
- A policy covering a two parents with children.
- A policy covering a single parent with children.

Employers pay 80 percent of the premium for the appropriate family policy. The employer's share is based on the average premium in the alliance area calculated on a "per worker" basis. This means that an employer pays a premium for each employee it hires, regardless of the work status of the employee's spouse. The "per worker" premium simplifies the system dramatically, eliminating the administrative burdens associated with coordination of benefits and switching family coverage when one spouse's work status changes. The "per worker" premium also spreads the cost of health coverage fairly across all employers.

Employers pay the same rate for an employee in a given family category, regardless of whether the employee chooses to enroll in a higher-cost plan or a lower-cost plan. An employer also may choose to pay part or all of the family share of the premium.

The individual or family pays the difference between 80 percent of the average premium and the actual premium of the health plan in which they choose to enroll. To enroll in an average-cost plan, an individual or family pays a maximum of 20 percent of the premium.

As a rule, individuals and families in which at least one person is employed outside the home are required to pay a maximum of 20 percent of the premium for their type of family to enroll in the average cost plan in their alliance area. Those who choose a less expensive plan pay less. Those who choose a more expensive plan pay more.

In either case, payments required from both employers and employees to purchase an average-cost plan are capped:

- Employers purchasing coverage through regional alliances are guaranteed that they will pay no more than 7.9 percent of payroll for health coverage for their workers.
- Businesses with fewer than 75 workers receive discounts that

peg their payments to a sliding scale based on size and average wage. The smallest, lowest-wage businesses are assured that they will pay no more than 3.5 percent of payroll for coverage.

- Individuals and families with incomes up to $40,000 are guaranteed that the cost of the 20 percent family share for an average-cost plan will not exceed 3.9 percent of income. Families with income below 150 percent of the poverty level receive further discounts.

HEALTH PLAN PREMIUM BIDS

Premiums for regional alliance health plans are established through a market-driven process, backed up by automatically triggered premium caps that limit the rate of increase in the weighted-average premium in the alliance as a whole.

Each health plan negotiates with a regional alliance a per capita bid for coverage of the federally guaranteed, comprehensive benefits package. The alliance adjusts this per capita bid by a "uniform per capita conversion factor" (determined by the alliance for all health plans in the alliance), which converts the bid to a premium that covers a single individual. Using premium class factors developed by the National Health Board for all alliances, the alliance converts each health plan's premiums for the other categories of family enrollment based on the individual premiums for that plan.

The premium is divided into two shares: an employer share and a family share.

EMPLOYER SHARE OF PREMIUMS

EMPLOYERS IN REGIONAL ALLIANCES

Employers pay 80 percent of the weighted-average premium in the alliance. The weighted-average premium is calculated for each family type, adjusted to account for the distribution of enrollment among plans across all family types.

To assure equity and simplicity, the employer share is fixed as a per-worker amount, based on each employee's family status. Because some couples and families include two working adults (i.e. they have "extra workers"), the employer payment per worker for family policies equals less than 80 percent of the average premium. However, total payments from all employers in the alliance for each family category amount to 80 percent of the average for that category. For the individual family category, there are no "extra workers," so the per worker premium equals 80 percent of the average.

The per-worker employer payment depends on the proportion of families in an alliance that include more than one worker. It is adjusted for each family category to reflect the number of such "extra workers." Both premiums and the number of extra workers in families vary from one regional alliance to another. Therefore, the relationship between the average premium and the average "per worker" premium paid by employers also varies from alliance to alliance. Within an alliance, however, the "per worker" premium does not vary from employer to employer.

The single parent and two-parent family categories are combined for the purpose of calculating the per worker premium, so an employer pays the same amount for a worker who is a single parent as for a worker who has a spouse and children.

The following table shows estimates of average premiums (in 1994 dollars) and employer premiums, by family category across the nation. These premiums, and the relationship between the full premium and the employer premium, will vary from alliance to alliance.

ESTIMATED AVERAGE PREMIUMS AND PREMIUMS PER WORKER BY FAMILY STATUS OF WORKER

TYPE OF POLICY	TOTAL AVERAGE PREMIUM	PER WORKER PREMIUM PAID BY AN EMPLOYER
Single Individual	$1,932	$1,546
Married Couple	$3,865	$2,125
Single Parent	$3,893	$2,479
Dual Parent	$4,360	$2,479

An employer may choose to pay some or all of the employee's share of the premium (as described in an earlier section).

DISCOUNTS FOR EMPLOYERS

No employer purchasing health coverage through a regional alliance is required to pay more than 7.9 percent of total payroll for health coverage.

Firms with fewer than 75 employees are eligible for discounts that limit their obligation to between 3.5 percent and 7.9 percent of payroll, depending on average wage and

size of firm. The sliding scale governing payments by small employers with average annual wages less than $24,000 is outlined in the following table:

ADDITIONAL DISCOUNTS FOR SMALL BUSINESSES

	AVERAGE WAGE FOR THE FIRM					
FIRM SIZE	$0–$12,000	$12,001–$15,000	$15,001–$18,000	$18,001–$21,000	$21,001–$24,000	OVER $24,000
<25	3.5	4.4	5.3	6.2	7.1	7.9
25–50	4.4	5.3	6.2	7.1	7.9	7.9
50–75	5.3	6.2	7.1	7.9	7.9	7.9

Employer size is based on average full-time equivalent employees during the year. Average annual wage is based on total wages paid divided by the number of full-time equivalent employees for the year.

Certain restrictions apply to the discounts on employer premiums:

- Large employers who join regional alliances gradually become eligible for the 7.9 percent cap over several years.
- The cap does not apply to employers operating corporate alliances who make payments to regional alliances on behalf of certain employees, such as part-time workers.
- The cap does not apply to the Federal Government, a State government, or a unit of local government until after the year 2002.
- The cap does not apply to premium surcharges to compensate for unpaid premiums (described under protections against contingencies).

PAYMENTS FOR FAMILIES IN MORE THAN ONE ALLIANCE

Families in which two full-time adult workers are eligible for coverage through different alliances choose the alliance in which they enroll. For example, if one spouse works for a large employer operating a corporate alliance and the other spouse works for an employer participating in the regional alliance, the family may choose coverage through either alliance.

The employer providing coverage through the chosen alliance pays its share of the premium as it normally would. The other employer -- whether it is a corporate alliance employer or a regional alliance employer -- pays the appropriate per worker premium for the regional alliance area, and the payment is forwarded to the alliance in which the family enrolls. A regional alliance employer always makes its payment to the regional alliance, and the alliance is responsible for forwarding payments to a corporate alliance.

PAYMENTS FOR PART-TIME WORKERS

Part-time workers obtain coverage through regional alliances regardless of where they are employed. However, a part-time worker who is the spouse or child of a full-time worker covered through a corporate alliance also receives coverage through the corporate alliance.

All employers of part-time workers pay a pro-rated portion of the appropriate per worker premium in the regional alliance. The payment is pro-rated based on the ratio of hours worked in a month to 120 hours. No employer payment is required for employees who work less than 40 hours per month, or for employees who are covered as a dependent child under a parent's policy.

CORPORATE ALLIANCE EMPLOYERS

Corporate alliance employers pay premiums to health plans serving the corporate alliance on behalf of employees and their families. Corporate alliance employers also make payments to regional alliances on behalf of workers not covered by the corporate alliance (e.g. part-time workers). For payments to regional alliances, they operate under the same rules as regional alliance employers (except for discounts).

In general, the monthly employer premium for a family in a corporate alliance is 80 percent of the weighted-average premium charged by the health plans offered by the corporate alliance for the appropriate type of family policy. Premiums -- and therefore, the employer share of the premium -- may also vary among geographically-based premium areas established by the corporate alliance.

Employers and workers in corporate alliances are not eligible for discounts funded by the federal government. However, corporate alliance employers are required to pay a larger share of the premium for families that earn full-time wages under $15,000-a-year. For those low-wage employees, the additional employer share of the premium equals the amount needed to cover 95 percent of the cost of the least-expensive plan available that uses the low or combination models for cost sharing.

LARGE EMPLOYERS THAT JOIN REGIONAL ALLIANCES

Because large employers eligible to form corporate alliances also may choose to enroll in regional alliances, consumers and employers in regional alliances must be protected from unintended incentives for large employers with older or less-healthy workers to choose that option.

To achieve that goal, premium payments for firms eligible to form corporate alliances that choose to join regional alliances are adjusted to the level of community rating over several years. Discounts also are phased-in.

To implement that policy, each regional alliance in which employees of a large firm live calculates a demographic adjustment for the firm's employees, based on characteristics of the employer's workforce during the year prior to joining regional alliances and a national formula developed by the Secretary of the Department of Labor. For the first four years after a large firm joins regional alliances, the employer pays the community-rated premium plus the demographic adjustment. The demographic adjustment cannot be less than zero (e.g. if an employer's workforce is younger than average).

Starting in the fifth year after the large firm joins regional alliances, the demographic adjustment is phased out over four years:

- In the fifth year, the employer pays the community-rated premiums plus 75 percent of demographic adjustment.
- In the sixth year, the employer pays the community-rated premiums plus 50 percent of the demographic adjustment.
- In the seventh year, the employer pays the community-rated premiums plus 25 percent of the demographic adjustment.
- Beginning in the eighth year, the employer pays the community-rated premiums and no demographic adjustment.

Similarly, large employers become eligible for the 7.9 percent of payroll cap on the employer share of premiums over several years. The cap does not apply during the first four years of participation in a regional alliance. Large employers receive 25 percent of any discount in the fifth year, 50 percent in the sixth year, 75 percent in the seventh year and the full discount beginning in the eighth year.

Discounts for which employees are eligible are available immediately.

SELF-EMPLOYED INDIVIDUALS

Self-employed individuals pay premiums to regional alliances as if they were small firms, and are eligible for discounts like other small employers (based on their net self-employment income). Premium contributions from employers on behalf of self-employed individuals reduce the employer share of the premium owed by the individual.

FAMILY SHARE OF PREMIUMS

Under the Health Security Act, each eligible individual and family is guaranteed health coverage through the alliance in which it enrolls. In cases in which families include workers eligible for two different alliances, the family chooses its alliance.

Alliances offer consumers a choice of health plans, some charging higher premiums than others. Within the same health plan, premiums vary only according to the four types of family policies: single individual, married couple without children, two-parent family with children and single-parent family. Health plan premiums are established based on community rating, and premiums do not vary from one area within a regional alliance to another.

Contributions by employers on behalf of employees and their families are used to provide each family with an alliance "credit" equal to 80 percent of the weighted-average premium in the alliance. Families who have a year of full-time employment (counting all employment by both spouses) earn the credit through their work. Families with less than a full year of work are responsible for repaying the unpaid portion of the credit that covers the employer share of the premium. The responsibility for paying the employer share for the portion of the year they were not working is subject to discounts based on income.

The alliance charges each family the difference between the credit and the premium of the health plan in which it enrolls. However, the family share of the premium is reduced by the following factors:

- Any discounts for which a low-income family is eligible.
- A credit to offset premium inflation caused by employers joining the regional alliance (using revenues obtained from the demographic adjustment payments made by these employers).
- A credit that passed on to families the benefit of any premium reductions as a result of premium caps.

The following example illustrates the choices among a range of health plans that might

face a single person in an alliance in which the average premium for an individual policy is $1,900. In the example, the individual is not eligible for a low-income discount, and there are no credits for large employers joining the regional alliances or for any premium reductions as a result of premium cap enforcement.

EXAMPLE: PREMIUMS AND PAYMENTS FOR SINGLE INDIVIDUALS

	TOTAL ANNUAL PREMIUM	ANNUAL ALLIANCE CREDIT	ANNUAL INDIVIDUAL PAYMENT
PLAN A	$1,600	$1,520	$80
PLAN B	$1,800	$1,520	$280
PLAN C	$2,000	$1,520	$480
PLAN D	$2,200	$1,520	$680

For employed persons, the family share of the premium is collected through withholding from wages and paid to the alliance by the employer. Families that have more than one worker choose which employer withholds premiums. Families that do not include a worker arrange payment for the family share of the premium directly, on a prospective basis, and at least monthly.

PREMIUM DISCOUNTS FOR FAMILIES IN REGIONAL ALLIANCES

Families are eligible to receive discounts on premiums based on their income. For families with annual income below $40,000, discounts ensure that a family pays no more than 3.9 percent of income to enroll in a plan at or below the average cost in the alliance. Further discounts are available for families with income below 150 percent of the poverty level.

The discount is calculated by subtracting the family's maximum payment obligation from 20 percent of the average premium in the alliance. For families with incomes above 150 percent of the poverty level (but below $40,000), the maximum payment obligation is equal to 3.9 percent of income.

For families with income below 150 percent of the poverty level, the maximum payment obligation is calculated on a sliding-scale basis and does not exceed 3.9 percent of income. Families receiving AFDC or SSI have no payment obligation, so their discounts are equal to 20 percent of the average premium.

For an eligible family, the discount reduces the family share of the premium regardless of which health plan the family chooses. The family share of the premium may not be reduced below zero.

The following example illustrates how the family share of the premium is calculated in cases in which the average premium in an alliance is $1,900 and a low-income individual is eligible for a discount of $200:

EXAMPLE: FAMILY SHARE OF PREMIUM WITH DISCOUNT

	TOTAL ANNUAL PREMIUM	ANNUAL ALLIANCE CREDIT	DISCOUNT	ANNUAL INDIVIDUAL PAYMENT
PLAN A	$1,600	$1,520	$200	$0
PLAN B	$1,800	$1,520	$200	$80
PLAN C	$2,000	$1,520	$200	$280
PLAN D	$2,200	$1,520	$200	$480

Because of limits on the capacity of health plans, individuals and families who receive discounts might not be able to enroll in a plan whose premium is average or lower. In such cases, the alliance increases the discount to permit enrollment in the next lowest-cost plan available.

Alliances determine eligibility for discounts. Families may apply for a discount at any time during a year. Alliances conduct year-end reconciliations based on actual income.

DISCOUNTS FOR COST SHARING

AFDC and SSI recipients enrolled in a lower or combination cost sharing plan are responsible for copayments equal to one-fifth of the standard amount (e.g. $2 per visit instead of $10 per visit).

In areas not served by a health plan that charges a premium at or below the average cost and uses the lower or combination cost-sharing models, individuals and families with incomes lower than 150 percent of poverty also qualify for discounts to cover co-payments and deductibles. Discounts reduce cost sharing for available plans at or below the average to the level of the lower cost-sharing model. For AFDC and SSI recipients, cost sharing is further reduced to one-fifth of the lower cost-sharing levels.

UNEMPLOYED FAMILIES AND FAMILIES WITHOUT EMPLOYER CONTRIBUTIONS

The Health Security Act contains special discounts and arrangements for families that do not include full-time workers.

OBLIGATION TO REPAY ALLIANCE CREDIT

For all families, the equivalent of full-time, year-round employment by one person (or split between two spouses) assures payment of the employer share of the premium for any health plan. Each month of full-time employment by a family member secures payment for one-twelfth of the employer share. Thus, for families in which one or more workers is employed part-time, on a temporary or intermittent basis, the employer share may be paid over the course of a year, based on the total number of hours worked by both spouses.

For families for whom the full employer premium is not paid, the obligation to pay unpaid portions depends on a family's "wage-adjusted income." The "wage adjustment" disregards:

- Unemployment compensation.
- Monthly wages up to $5,000 for each month for which an employer premium is paid.
- Net earnings from self employment.

DISCOUNTS

Families with wage-adjusted incomes below 250 percent of the poverty level are eligible for discounts on the employer share. The discounts are calculated on a sliding scale basis.

Families with wage-adjusted income of less than $1,000 are excused from making any payment. Families that receive Aid to Families with Dependent Children and Supplemental Security Income also have no obligation to pay the employer share of the premium.

Discounts are administered by regional alliances through an end-of-the-year reconciliation process.

EARLY RETIREES

Beginning in 1998, eligible retirees, their spouses and children are treated as full-time employees. They are obligated to pay no more than the family share of the premium for their health plan.

An eligible retiree is someone who meets all of the following conditions:

- Is between the ages of 55 and 65.
- Is not employed on a full-time basis.
- Was employed for the period of time required to earn eligibility for Medicare Part A hospital insurance (40 quarters).
- Is not eligible for Medicare coverage.

If an eligible retiree dies, the surviving spouse and children remain eligible for the retiree benefit until the eligible retiree would have turned age 65, unless the spouse turns 65, is employed or remarries.

Beginning in 1998, employers who contributed at least 20 percent of the cost for an early retiree as of October 1, 1993 must contribute at least 20 percent of the average premium in that retiree's alliance area.

EMPLOYED MEDICARE BENEFICIARIES

Individuals eligible for Medicare who receive coverage through a regional alliance employer during a year are not obligated to pay the unpaid employer share for periods in that year for which they are not employed full time.

MEDICAID-RELATED PAYMENTS: SUMMARY OF TITLE IX

STATE MAINTENANCE OF EFFORT FOR MEDICAID

Although the Medicaid program changes dramatically under health reform, participating States maintain their current commitment to Medicaid health coverage. Those payments cover premiums for the guaranteed comprehensive benefits package on behalf of Medicaid recipients who do not receive cash assistance.

The maintenance of effort amount is based on the sum of:

- State Medicaid expenditures in FY 1993 for services covered under the nationally guaranteed comprehensive benefits package for children and adults who do not receive Aid to Families with Dependent Children and Supplemental Security Income.

- State Medicaid expenditures in FY 1993 on behalf of children eligible for the new federal program for wrap-around benefits who are receiving AFDC or SSI, and for non-long term care benefits not in the comprehensive benefits package.

- State Medicaid expenditures for disproportionate share in FY 1993 attributable to non-cash assistance Medicaid recipients.

This amount is increased through the first year of participation by a state based on the projected national increase in Medicaid expenditures for non-cash recipients, and the projected national increase in disproportionate share hospital payments.

After implementation of the Health Security Act in a state, required state maintenance of effort contributions increase only by the general health care inflation factor (used in enforcing premium caps) plus projected growth in the U.S. population under age 65.

PREMIUM PAYMENTS ON BEHALF OF AFDC AND SSI RECIPIENTS

Each participating State makes an annual premium payment to regional alliances on behalf of each individual covered under Aid to Families with Dependent Children and Supplemental Security Income.

Separate premium payments are calculated for AFDC and for SSI recipients for a state.

The AFDC premium is based on 95 percent of per capita state Medicaid expenditures in FY 1993 made on behalf of AFDC recipients for services covered under the nationally guaranteed comprehensive benefits package.

This amount is increased through the year before the first year of state participation based on the projected national increase in Medicaid expenditures for AFDC recipients. The amount is reduced if state Medicaid spending for AFDC recipients grows more slowly during this period (after adjustments for reductions in benefits, arbitrary reductions in payment rates, or a reduction in access).

Beginning in the first year of state participation, the AFDC premium is inflated by the general health care inflation factor.

If a state has more than one regional alliance, the AFDC premium is adjusted to account for variations in health care costs among alliance areas.

The premium for SSI recipients is determined in a similar manner, using SSI inflation projections.

The federal government also makes payments to each regional alliance to cover the federal share of premium payments on behalf of AFDC and SSI recipients. The payment is calculated in the same manner as state payments except that Federal payments are based on the percentage of medical assistance paid by the federal government in each state.

PUERTO RICO AND OTHER TERRITORIES

Subject to guidelines, the Secretary of the Department of Health and Human Services may waive or modify financial requirements for participating states for to Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

NARROWING GEOGRAPHIC VARIATIONS IN MEDICAID-RELATED PAYMENTS

The National Health Board establishes an advisory commission to examine methods to reduce the variation in premium targets across alliances and to reduce variations across states in AFDC/SSI premium payments and maintenance of effort amounts. The advisory commission examines methods for reducing variations in Medicaid-related payments because of practice patterns, historical differences in reimbursement levels and benefits covered by state Medicaid programs.

By July 1, 1995, the National Health Board must submit to Congress a proposed method for reducing variation across states in AFDC and SSI premium payments and maintenance of effort amounts by the year 2002. The Board's recommendations must reduce variations in a manner that would be budget neutral for total federal and state payments, and take into account the fiscal capacity of states.

The Board's recommendation goes into effect unless disapproved by a joint resolution of Congress, considered under an expedited process based on the Defense Base Closure and Realignment Act of 1990.

PAYMENTS TO REGIONAL ALLIANCE HEALTH PLANS

In calculating how much they pay health plans, regional alliances factor in an adjustment to account for the federal and state SSI and AFDC premium payments and the number of members covered under AFDC and SSI throughout the alliance.

This blended premium equals a weighted average of the plan bid, the AFDC premium amount, and the SSI premium amount. In calculating the weighted average, alliance-wide enrollments of AFDC recipients, SSI recipients, and other enrollees are used. Therefore, each plan is paid the same amount for each person enrolled (adjusted for the risk characteristics of its enrollees), regardless of whether or not that person receives cash assistance.

ENFORCEABLE CAPS: SUMMARY OF TITLE VI

Health care expenditures covered by enforceable caps include premiums paid to cover the guaranteed comprehensive benefit package whether paid by employers, employees, or individuals. Medicare and Medicaid expenditures are controlled separately.

Supplemental benefits beyond the comprehensive benefit package, as well as workers' compensation and auto insurance benefits, are not included. Premiums for insurance policies providing coverage for cost sharing are also not included.

ANNUAL INCREASES

The rate of growth in premiums for health plans offered through regional alliances is limited by an inflation factor. Regional alliance inflation factors are as follows:

- Projected increase in the Consumer Price Index (CPI) plus 1.5 percentage points for 1996
- Projected increase in the CPI plus 1.0 percentage points for 1997
- Projected increase in the CPI plus 0.5 percentage points for 1998
- Projected increase in the CPI for 1999 and 2000.

In 1998, the National Health Board will submit to Congress recommendations for establishing the allowable rate of growth in health insurance premiums for years beginning with 2000.

If Congress fails to enact a law specifying a health care inflation factor, the factor will be based on change in the CPI and the average annual percentage change in real, per capita gross domestic product during the previous three years.

These inflation factors apply to the weighted average *premium* (per person) in each alliance. Total health *expenditures* in regional alliances for the guaranteed benefits package increase at these rates plus increases in population.

The National Health Board adjusts the inflation factor for each alliance to reflect:

- Demographic changes in the alliance population due to large employer joining the regional alliance.

- Demographic shifts in the population from one alliance to another.

The Board consults with states and alliances prior to the establishment of the annual inflation factor.

NATIONAL PER CAPITA PREMIUM TARGET

The National Health Board calculates a national per capita premium target for regional alliances based on current (1993) per capita health expenditures that pay for services covered in the guaranteed benefits package projected to 1995 based on anticipated increases in private sector health spending and to 1996 based on the inflation factor for that year. This amount is adjusted as follows:

- To account for anticipated increases in utilization as a result of the inclusion of individuals and families who are currently uninsured or have inadequate coverage. The uninsured are assumed to be covered at the full average cost of services.

- To subtract current allowances for uncompensated care, which will no longer be necessary with universal coverage.

- Because employees of large employers, Medicare beneficiaries, and AFDC and SSI recipients are covered through separate funding streams, health spending for these groups is not included in the calculation of the national per capita premium target.

CALCULATION OF ALLIANCE PER CAPITA PREMIUM TARGETS

The Board calculates for each alliance a per capita premium target for 1996, using the national per capita premium target as a reference point. For each alliance, the Board adjusts the national per capita premium target for current regional variations in health care spending and to take into account the proportion of the population without health insurance or with inadequate coverage. To measure regional variations in health care spending, the Board uses such factors as:

- Variations in insurance premiums across states based on surveys and other data.

- Variations in per capita health spending by state, as measured by the Health Care Financing Administration.

- Variations across states in per capita spending under the Medicare program.

- Area rating factors commonly used by actuaries.

The Board establishes the per capita premium targets for alliances so that the weighted average of the alliance target equals the national per capita premium target. For any year, the per capita premium target for an alliance is equal to its target for the previous year, increased by the alliance's inflation factor.

FIRST YEAR BIDDING AND NEGOTIATION PROCESS

Each alliance conducts a bidding and negotiation process with health plans. The National Health Board provides alliances with information and technical assistance to aid in the bidding process. For the first year of implementation, the bidding is conducted either by providing plans with the alliance's premium target prior to bidding, or by inviting blind bids followed by negotiations and re-bidding.

Once an alliance is satisfied with the negotiated health plan premiums, it submits them to the National Health Board for review. The first-year bidding process and the submission of bids to the Board occur earlier than in subsequent years to allow time for a more thorough review by the National Health Board and possible re-negotiation of premiums.

NATIONAL BOARD REVIEW

The Board calculates an estimated weighted-average premium for each alliance based on the bids submitted by the alliance and the projected distribution of enrollment across plans. After the first year, the estimated weighted-average premium is calculated as the average of the bids weighted by actual enrollment in each plan for the prior year. Special rules cover adjustments to account for plans entering or leaving the alliance.

ENFORCEMENT OF PREMIUM TARGETS

If the estimated weighted-average premium based on final bids is below the alliance's premium target, then no enforcement of premium caps occurs.

If, however, the estimated weighted-average premium for an alliance exceeds the alliance's premium target, a preemptive enforcement mechanism is triggered.

Preemptive enforcement works as follows:

- An "excess premium amount" is calculated for each health plan in the alliance. In the first year of implementation in a state, the excess premium amount is the amount by

which a health plan's bid exceeded the premium target for the alliance. That is, only plans whose bids are higher than the alliance's premium target are assigned an excess premium amount.

- In subsequent years, the excess premium amount is the amount by which a health plan's premium *increase* exceeds the alliance's allowed increase. That is, the excess premium amount equals the amount by which the plan's bid exceeds the premium it was paid the previous year plus the allowable *dollar* increase in the alliance's weighted-average premium. This approach allows for larger increase for lower-cost plans and a smaller increase for higher-cost plans.

- For each plan with an excess premium amount, the alliance calculates a new premium equal to the plan's bid, minus the plan's excess premium amount multiplied by an "adjustment factor" for the alliance. This new premium determines the alliance's payment to the plan for such participants enrolled. The alliance's "adjustment factor" is calculated to bring the weighted-average premium among all health plans in the alliance in line with the alliance target.

- A plan may voluntarily lower its premium to the amount calculated by the Board. A plan may also build into its contracts with health providers automatic reductions in fees to hold spending in line with premium caps.

- If a plan does not voluntarily reduce its premium bid, the alliance automatically adjusts its premium payments to equal the amount allowed under the premium cap. Payments from the plan to its providers are automatically reduced by the same percentage that the plan's proposed premium was reduced, plus an additional amount to account for increases in the volume of services resulting from lower payment rates.

- For providers in a plan's network (e.g. in an HMO or PPO), certification requirements for health plans specify that the contract between the plan and its providers include automatic payment reductions if premium caps are applied. For fee-for-service providers, the plan pays according to the negotiated fee schedule, less the amount that the plan's proposed premium was reduced (and the adjustment for increased volume). Providers may not bill patients for excess fees above this amount.

- Employers in the alliance pay 80 percent of the weighted-average premium, less any reductions as a result of application of premium caps. Employer payments, therefore, fall in line with the alliance's premium target.

- Consumers also benefit from reductions in premium growth as a result of the cap on the rate of increase for insurance premiums. Each consumer pays his or her share of the premium, minus the average reduction imposed by the cap across all health plans in the alliance.

ADJUSTING THE PREMIUM TARGET FOR EXCESS SPENDING IN A PREVIOUS YEAR

In general, as described above, the premium inflation factor equals the increase in the Consumer Price Index (plus an additional amount in the first three years). If, however, an alliance's actual weighted-average premium in a given year exceeds its premium target, then the premium target for that alliance is reduced for the following two years to recover excess spending.

NARROWING GEOGRAPHIC VARIATIONS IN PREMIUM TARGETS

The National Health Board provides states and alliances with information about regional differences in health care costs and practice patterns and appoints an advisory commission to recommend adjustments to the methodology for calculating premium targets.

By July 1, 1995, the Board must submit to Congress a proposed methodology for eliminating differences in per capita premium targets among regions as a result of variations in practice patterns.

The recommendations must achieve the goal of eliminating differences due to practice patterns by the year 2002.

The proposed method may take into account regional variations in demographic or health status and in health care input prices, based on the availability of accurate proxies for measuring price variation.

The method recommended must ensure that the national average of alliance premium targets remains unchanged.

The Board's recommendation goes into effect unless disapproved by a joint resolution of Congress, considered under an expedited process based on the Defense Base Closure and Realignment Act of 1990.

STATE FINANCIAL INCENTIVES FOR COST CONTAINMENT

A state may elect to assume responsibility for cost containment. Federal enforcement of premium caps does not change, but financial incentives are provided for states that are able to control spending below the caps.

If the weighted-average premium across all alliances in a state is below the weighted-average target for the state's alliances, the state retains half of the estimated savings that result in federal spending for discounts for employers and low-income families.

In order to control health care costs, a state may regulate payments to providers. Such regulation may not cause a corporate alliance health plan to be charged rates different from those charged other plans or otherwise discriminate against corporate alliance health plans.

PREMIUM TARGETS FOR CORPORATE ALLIANCES

Employers eligible to operate corporate alliance may do so provided that they comply with national cost-containment goals. Large employers whose health plans do not meet national spending goals are required to purchase coverage through regional alliances.

The allowed rate of growth for corporate alliance premiums is the same as the inflation factor for regional alliances (calculated based on a three year average).

The National Health Board develops a methodology for calculating an annual premium equivalent within a corporate alliance. Beginning after the third year of implementation of health reform, each corporate alliance annually reports its average premium equivalent for the guaranteed benefits package for the previous three years to the Department of Labor.

If the increase in the three-year premium equivalent exceeds the allowed rate of growth during two of any three years, the Department of Labor requires the employer to purchase health coverage through a regional alliance. An employer may petition the Department of Labor for an adjustment in its inflation factor to compensate for unusual changes in the risk profile of its workforce.

FEDERAL PAYMENTS TO ALLIANCES AND SAFEGUARDS AGAINST CONTINGENCIES: SUMMARY OF TITLE IX

The Health Security Act builds in ample safeguards to protect American consumers, and employers from even remote contingencies related to the financing of health coverage.

The premium-based financing system provides mechanisms to ensure financial stability for all heath plans and alliances. It also specifically limits the magnitude of federal budget commitments to fund discounts for small businesses and families through an entitlement cap. The cap is based on reasonable estimates of federal spending for discounts, including a 15% "cushion."

FEDERAL PAYMENTS TO ALLIANCES

Beginning Jan. 1, 1996, the Department of Health and Human Services provides each regional alliance with funds that cover the cost of discounts provided to small employer and American families under a capped entitlement.

The federal alliance payment equals the payment obligations of each alliance minus amounts receivable. This difference reflects the amount of discounts provided to employers and families. Payment obligations include payments to plans for reductions in cost sharing and administrative expenses. Amounts receivable by the alliance include premiums owed by families and employers and amounts payable by Federal and State Governments for maintenance of effort and for premiums on behalf of AFDC and SSI recipients.

The Federal Government is not responsible for premium amounts owed to an alliance but not collected, or for excessive administrative errors or misappropriations.

For a single-payer State, the Secretary pays an amount equal to the amount that alliances in the state would have received.

FEDERAL ENTITLEMENT CAP

Before the beginning of each year, the Secretary estimates the total federal obligation for each regional alliance and reports an estimate of the total amount owed for all alliances. The total amount of Federal alliance payments for a fiscal year may not exceed specified limits.

For fiscal years 1996 through 2000, appropriations to pay for those obligations may not exceed the following amounts:

- $10.3 billion for fiscal year 1996.
- $28.3 billion for fiscal year 1997.
- $75.6 billion for fiscal year 1998.
- $78.9 billion for fiscal year 1999.
- $81.0 billion for fiscal year 2000.

If the projected Consumer Price Index differs significantly from projections by the Council of Economic Advisors to the President in October 1993, the Secretary may adjust the limits on federal payments to account for the difference.

For subsequent years, the limit is updated using a formula based on increases in CPI, U.S. population, and real per capita Gross Domestic Product.

If payments to alliances in a year total less than the amount allowed, the surplus accumulates and is available for the same purpose in future years.

If projections show that the total amount allowed nationwide will not be sufficient to fund discounts during a particular fiscal year, the Secretary of the Department of Health and Human Services must notify the President, the Congress and each regional alliance of the anticipated shortfall.

Within 30 days of receiving notice, the President must submit to Congress specific legislative recommendations to eliminate the shortfall. Congress considers the President's recommendations under an expedited process. If a joint resolution is introduced that contains the President's recommendations, that resolution is considered in a manner described in the Defense Base Closure and Realignment Act of 1990.

LOANS TO COVER CASH-FLOW SHORTFALLS

The Secretary makes loans available to regional alliances to cover temporary cash-flow shortfalls caused by discrepancies in estimation, administrative errors and the timing of collections for premiums and other receipts.

The Secretary sets terms and conditions for loans to regional alliances in consultation with the Secretary of the Treasury, taking into account cash management rules established by the Department of Treasury. Loans are repayable over no more than two years. Alliances pay interest at a rate determined by the Secretary of the Treasury, taking into consideration average rates on marketable obligations of the United States at the time.