As a condition of receiving a loan, a regional alliance agrees to make appropriate adjustments to future premiums or collections to assure repayment. Alliances repay loans through reductions in payments by the Federal government or temporary increases in the State maintenance-of-effort payments.

ADD ON FOR COLLECTION SHORTFALL

As an additional protection to guarantee the fiscal soundness of alliances, if an alliance fails to collect the full amount of premiums owed, employers and families covered through the alliance pay a small additional payment to cover the shortfall.

The amount of the add-on is based on the total amount of shortfall per person covered in the alliance. The add-on is estimated by the alliance, and adjusted the following year for under- or over-estimates. Responsibility for covering the shortfall is divided between employers and families based on the 80 percent/20 percent division of shares for premium payments.

TAX INCENTIVES AND REVENUE PROVISIONS

OVERVIEW

The Health Security Act clarifies a wide range of tax policies related to the purchase of health care and coverage. It also includes several new tax provisions and incentives in light of national health care reform, including increasing the deduction for health insurance costs for self-employed individuals to 100 percent, changes to the tax code to foster the purchase of private long-term care insurance and to support economic independence for disabled people who work.

The Act proposes to raise relatively little new revenue, relying on an increase in the federal excise tax on tobacco products as its primary source of new tax funding. As a matter of equity, it proposes a 1 percent assessment on large corporations (those with more than 5000 employees) that elect to organize corporate alliances. Revenue collected from corporate alliances funds academic health centers and contributes to the cost of coverage for unemployed American workers and their families -- ensuring that businesses and individuals who purchase coverage through regional alliances do not bear the burden alone.

Beginning in 2004, only employer contributions for the nationally guaranteed comprehensive benefit package are excluded from employee income for tax purposes.

Also as a matter of fairness, the Health Security Act asks older Americans who have high incomes -- more than $90,000-a-year for an individual and $115,000 for a couple -- to pay a larger portion of the actual cost of Medicare Part B coverage.

TAX INCENTIVES AND REVENUE PROVISIONS: SUMMARY OF TITLE VII

INCREASE IN FEDERAL EXCISE TAX ON TOBACCO PRODUCTS

The federal excise tax on cigarettes increases by $.75 per pack to $.99 per pack effective Oct. 1, 1994. Federal excise taxes on other tobacco products increase by proportionate amounts.

ASSESSMENTS ON CORPORATE ALLIANCE EMPLOYERS

An annual one-percent assessment on payroll is levied on firms that choose to form corporate alliances. The assessment generally is effective beginning January 1, 1996.

ADDITIONAL PREMIUMS FOR MEDICARE RECIPIENTS AND RETIREES WITH HIGH INCOMES

Individuals with incomes above $90,000 and couples with combined incomes above $115,000 who enroll in Medicare Part B pay 75 percent of program costs.

Subject to certain exceptions, combined income equals a taxpayer's adjusted gross income including taxable Social Security benefits, plus tax-exempt interest income. Because additional premiums are based on income, they are administered through the income tax system, effective Jan. 1, 1996.

Beginning Jan. 1, 2000, retired individuals between the ages of 55 and 64 are eligible for a discount to cover the employer share of health insurance premiums. High-income taxpayers are required to repay the discount through individual income taxes beginning on the same date the discount commences.

TAX TREATMENT OF CHAPTER S CORPORATIONS

Shareholders who own two percent or more of the stock in a service industry Subchapter S corporation are required to pay self-employment Social Security tax on non-wage income from the Subchapter S corporation, effective beginning Dec. 31, 1995.

Limited partners, if they materially participate, will be taxed in a similar manner, effective on the same date.

EXTENSION OF MEDICARE HOSPITAL INSURANCE TAX TO STATE AND LOCAL GOVERNMENT EMPLOYEES

The requirement to participate in Medicare coverage extends to all employees of state and local governments not otherwise covered under present law, effective October 1, 1995. These employees and their employers become liable for the hospital insurance portion of the FICA tax, and employees earn credit toward Medicare eligibility based on their covered earnings.

LIMITS ON EXCLUSION OF EMPLOYER-PROVIDED HEALTH BENEFITS

Employer contributions for health benefits through cafeteria plans or flexible spending arrangements are no longer excluded from employee income as of Jan. 1, 1997.

Beginning in 2004, only employer contributions for the nationally guaranteed, comprehensive benefit package (up to 100 percent of the cost of the package) and associated

cost sharing are excluded from income for purposes of calculating individual income and employment taxes. After that date, employees' taxable income and wages include employer-paid premiums for coverage of supplemental benefits.

DEDUCTIONS FOR SELF-EMPLOYED INDIVIDUALS

The deduction from individual income tax liability for self-employed taxpayers increases to 100 percent of the amount paid for health insurance, not to exceed the full cost of the comprehensive benefit package. A self-employed taxpayer may begin claiming the full deduction when the state in which he or she resides establishes a regional alliance, or Jan. 1, 1997, whichever comes first.

LIMITS ON PREPAYMENT OF MEDICAL INSURANCE PREMIUMS

The itemized deduction for medical expenses is amended to provide that if a taxpayer pays a premium or other expenditures for medical care whose benefit extends substantially beyond 12 months after the payment, the amount is treated as paid over the entire period. The provision applies to payments after Dec. 31, 1996.

EMPLOYMENT STATUS

To prevent mischaracterization of employees as independent contractors, the Treasury Department is authorized to prescribe regulations for determining the employment status of workers for tax purposes. The regulations must give significant weight to the current common law test for employee status. The penalty for not reporting a payment to an independent contractor is increased to the higher of $50 or five percent of the payment.

POST-RETIREMENT MEDICAL AND LIFE INSURANCE RESERVES AND RETIREE HEALTH ACCOUNTS

Additions to reserves for post-retirement medical or life benefits in funded welfare benefit plans (typically VEBAs) are determined on a level basis over a period of at least 10 years. Employers are no longer allowed to contribute to 401(h) accounts, effective Jan. 1, 1995. Existing funds in 401(h) accounts continue to receive tax treatment under current law until withdrawn.

COBRA

Because the Health Security Act creates seamless health coverage for all Americans,

the requirement to provide health care continuation coverage -- commonly referred to as "COBRA" coverage -- under group health plans is repealed as of Jan. 1, 1998, or the date on which all states have a regional alliance in operation.

In the interim period, COBRA coverage for employees and beneficiaries terminates when the recipient is eligible to participate in a health care plan through an alliance.

TAX TREATMENT OF HEALTH CARE ORGANIZATIONS

Hospitals and other nonprofit health care providers continue to be eligible for tax exemption as charitable organizations under section 501(c)(3). In addition to requirements under existing law, non-profit health care providers are required to assess health needs in their communities and develop a plan to meet them. Needs assessment and plan development occur at least annually and with the participation of community representatives, effective for taxable years after 1996.

Two differences between the taxation of Blue Cross/Blue Shield organizations and other property and casualty insurance companies are eliminated: Blue Cross/Blue Shield is no longer allowed to deduct the difference between 25 percent of health claims and adjusted surplus. In addition, Blue Cross/Blue Shield organizations are required to include 20 percent of increase in their unearned premium reserves in taxable income. Both provisions are phased in beginning with taxable years after 1996.

Regional health alliances are exempt from federal income tax.

ACCELERATED DEATH BENEFITS

For taxable years beginning after 1993, distributions under a life insurance contract on the life of an individual who is terminally ill are treated as an amount paid by reason of death. A terminally ill individual is someone whom an insurer has determined, after receipt of an acceptable physician's certification, an illness or physical condition that can reasonably be expected to result in death within 12 months.

TAX-EXEMPT BONDS

Bond proceeds that benefit a health care alliance or State guaranty fund are characterized as used in a private business. Bond issues in which more than 10 percent of the proceeds finance the activities of health care alliances or State guaranty funds generally are private activity bonds and not tax-exempt.

DISCLOSURE OF INFORMATION

The Internal Revenue Service is permitted to disclose return information to federal and State agencies for the administration of certain programs providing assistance under the Health Security Act.

V. IMPROVING THE DELIVERY OF SERVICES

ESTABLISHING A NEW HEALTH WORKFORCE

OVERVIEW

The Health Security Act takes assertive steps to strike a new balance in the mix of primary and specialist health professionals.

- Adjusting the balance in the graduate training of physicians from other specialties to primary care.
- Encouraging community-based training for medical residents.
- Increasing investments in the training of advance practice nurses and physician assistants.
- Recruiting and supporting health professionals among minorities.

The Health Security Act includes major proposals related to the health care workforce because the growing imbalance in the mix of primary and specialist physicians and underuse of health professionals who are not physicians represents a major source of rising costs in American health care.

Today, only 30 percent of new physicians are expected to enter fields of medicine considered a part of primary care -- a proportion that is declining. Less than a third of all American doctors practice as generalists, compared to between 50 percent and 70 percent in other industrialized countries. Partly as a result, primary care and public health prevention efforts receive too little attention, and rates of surgery and other major medical interventions are higher than in other countries.

The use of public resources to support medical training without regard to the mix of physicians and other health professionals helps to perpetuate the imbalance between specialist and primary care in the United States.

Current federal policy related to graduate medical education pays teaching hospitals with accredited programs on an institutional-specific, per-resident basis, with minimal consideration of location, field of specialization, or eventual impact on the health care system.

Funds for training of nurses, physician assistants and advance practice nurses is inadequate. Support is inadequate as well for the training of minority health professionals and for increasing the supply of doctors, nurses and other providers in rural and underserved urban communities.

The Health Security Act creates specially designated national funds into which both

Medicare and the private insurance sector contribute to the support of graduate medical education, training of advance practice nurses, support for the special missions of academic health centers in research, teaching, and provide specialized services and complex care. The new all-payer accounts make explicit these investment decisions that are made through an implicit system today.

In addition to refocusing investments for physician training and increasing support for advance practice nurses and other health professionals, the Health Security Act includes proactive steps to ensure workers at all levels of the health care industry the opportunity to upgrade their skills and shape successful careers.

ESTABLISHING A NEW HEALTH WORKFORCE: SUMMARY OF TITLE III, SUBTITLE A

NATIONAL COUNCIL ON GRADUATE MEDICAL EDUCATION

The Health Security Act establishes the National Council on Graduate Medical Education under the Department of Health and Human Services composed of representatives of consumers, physicians in private practice, medical school faculty, representatives from health alliances and plans, and others determined by the Secretary.

AUTHORIZED POSITIONS IN SPECIALTY TRAINING

Approved physician training programs, including those in ambulatory settings, enter into agreement that the number of enrollees in their programs be as instructed by the National Council on Graduate Medical Education.

ENCOURAGING PRIMARY CARE

The National Council on Graduate Medical Education:

- Determines for each academic year, the number of individuals who are authorized to be enrolled in eligible training programs.
- Designates the number of training positions in each medical specialty for three academic years beginning with 1998–99.
- Achieves a new balance in the mix of specialist and primary care doctors trained. By the academic year 2002–2003 at least 55 percent of residents are to complete training programs in primary care, including family medicine, general internal medicine, general pediatrics, or obstetrics and gynecology.
- Ensures that the minimum number of residency training positions correlates with the number of graduates from U.S. medical schools by the academic year 2003–2004.

ALLOCATING POSITIONS AMONG SPECIALTIES AND PROGRAMS

- The National Health Council allocates the designated annual number of specialty positions nationwide among eligible programs.

- Allocation is done for three years at a time, with at least one year advance notice to programs. The first allocations begin in the academic year 1998–1999.

- In making allocations among specialties and programs the Council will consider:

  - The need for additional practitioners in a specialty.

  - The historical distribution of positions among geographic areas and quality of training programs.

  - The extent to which the program includes trainees who are members of racial or ethnic minority groups, and the extent to which the group is under-represented in the field of medicine, and in the specialty.

  - The recommendations of organizations representing physicians and organizations representing consumers.

FEDERAL FORMULA PAYMENTS TO PHYSICIAN TRAINING PROGRAMS

- Approved physician training programs apply for payments beginning January 1, 1996. Payments are made directly to eligible programs. Institutions within which programs operate must agree that payments made by the Secretary will go to the program.

- In any year, an institution may participate as a provider in a regional or corporate alliance health plan only if each training program which operates within the institution is approved and meets the requirements for receiving payments.

ANNUAL HEALTH PROFESSIONAL WORKFORCE ACCOUNT

Specially earmarked payments from Medicare and regional and corporate alliances fund the new Annual Health Professional Workforce Account, which consists of:

Calendar year 1996 -- $3.20 billion
Calendar year 1997 -- $3.55 billion
Calendar year 1998 -- $4.80 billion
Calendar years 1999 and 2000 -- $5.80 billion

After the calendar year 2000, payment is based on $5.8 billion adjusted by the general health care inflation factor for each year.

Payments to each eligible program equal the full-time equivalent number of residents in the program multiplied by the national average of the costs of training residents.

Payments under Medicare for direct graduate medical education costs are terminated for cost reporting periods beginning on or after October 1, 1995.

TRANSITIONAL PAYMENTS

Beginning in calendar years 1998, institutions that reduce their residency slots apply for payments to assist with the cost of transition over a four year period.

- The loss must be as a result of the National Council's allocations, and is keyed to the aggregate number of positions in the institution in academic year 1993–1994.

- Payments are based on the number of specialty positions lost and the national average salary of training participants in 1992–1993, adjusted by CPI and regional wage factors.

- Payments begin at 100 percent, in the first calendar and are based the national average salary for residents, adjusted for regional wage differences. They decline by 25 percent for each of the subsequent three years and are then phased out.

INSTITUTIONAL COSTS OF GRADUATE NURSING EDUCATION

- A National Council on Graduate Nurse Education is established under the Department of Health and Human Services, and determines the number of individuals authorized to be enrolled in eligible programs in the same manner that the National Council on Graduate Medical Education determines positions for physician residencies.

- Graduate nurse training includes education of nurse practitioners, nurse midwives, nurse anesthetists, and clinical nurse specialties determined by the Secretary to require advanced education.

- Payments are made to graduate nurse training programs which apply to the Secretary of the Department of Health and Human Services.

- For nursing training programs, $200 million is transferred to the Secretary of the Department of Health and Human Services from the Department of Treasury.

OTHER TRAINING PROGRAMS

An additional $400 million is authorized for FY 1994 and each year thereafter for other workforce programs under the Department of Health and Human Services. Increased federal funding supports the following through existing and enhanced programs under the

Public Health Service Act:

- Training of primary care physicians and physician assistants, retraining midcareer physicians in primary care, expanding the supply of physicians with special training in rural and inner-city medically underserved areas, training in managed care, cost-effective practice management and quality improvement, and development of information on workforce issues.

- Training of under-represented minorities and disadvantaged persons, including recruitment, retention, and financial assistance for persons entering medicine, nursing, public health and other health professions and faculty development.

- Training of nurses, including mid-level providers, baccalaureate-level nursing for career in teaching, community health service, interdisciplinary school-based nursing and research, and addressing inappropriate practice barriers.

- Training for providers and administrators in managed care, practice management, continuous quality improvement, and culturally-sensitive care.

TAX INCENTIVES FOR HEALTH SERVICE PROVIDERS (Title VIII)

A physician who works full-time in an area designated as having a shortage of health professionals and who obtains required certification from the Department of Health and Human Services is eligible for a tax credit of $1,000 per month for up to 60 months.

To qualify for the full credit, physicians must practice in the underserved area for five consecutive years.

For physicians, an additional $10,000 investment in medical equipment may be claimed as expenses, effective for items placed in service after 1994.

Certified nurse-midwives, nurse practitioners, and physician assistants who work in health professional shortage areas may receive a tax credit of $500 per month for up to 60 months, subject to the same restrictions, effective for taxable years beginning after 1994.

PROGRAMS OF THE SECRETARY OF LABOR

The Secretary of Labor is authorized $200 million annually beginning FY 1994 to establish programs to:

- Upgrade skills, retraining displaced workers, and to improve the quality and workforce

- Assist health care workers in career advancement.
- Develop health worker job banks.
- Provide for joint labor–management decision–making on workplace matters.
- Facilitate the comprehensive workforce adjustment initiative.

NATIONAL INSTITUTE FOR HEALTH CARE WORKFORCE DEVELOPMENT

The Secretaries of the Departments of Health and Human Services and Labor jointly establish a National Institute for Health Workforce Development to make recommendations regarding:

- The supply of health care workers needed for proper staffing of the health care delivery systems serving the regional and corporate alliance plans.
- The impact of the Act and of related changes on health care workers regarding education, training, and career development.
- The development and implementation of high–performance, high quality health care delivery systems, including employee participation committee systems and employee team systems.

The Secretaries establish an Advisory Board composed of the Secretary of Labor, and Health and Human Services, and representatives of workers, providers, educational entities, consumers, and others as deemed appropriate.

PROGRAMS RELATED TO REDEPLOYMENT OF HEALTH CARE WORKERS

- State programs for home and community–based services for individuals with disabilities are required to provide in the state plan for negotiations with labor unions representing the employees of affected hospitals or other facilities, assessment of the impact on workers, and methods of redeploying workers affected.
- State plans for integration of the mental health and substance abuse services will provide for negotiation with labor unions of affected hospitals or other facilities, assessment of the impact on workers, and methods of redeploying workers affected.

ACADEMIC HEALTH CENTERS

OVERVIEW

Recognizing the critical contribution of America's academic health centers and teaching hospitals, the Health Security Act creates a national account to support the extra costs associated with their mission, including research, development of new medical technology, treatment of rare and unusually severe illnesses and specialized patient care.

Medicare payments and a surcharge on private health insurance premiums flow into a national account from which teaching hospitals and academic health centers that operate teaching hospitals receive support. The account totals $3.1 billion in 1996.

Funds from the account are distributed to academic health centers and teaching hospitals based on a formula which considers the ratio of residents to beds, as well as total inpatient and outpatient revenues.

This new separate payment is intended as reimbursement for costs incurred over and above the cost of routine patient care. Only institutional costs not covered by typical fees for patient care are designed to be included in the formula.

This approach represents a revision of the current Medicare indirect medical education payment formula to factor in the impact of universal coverage. The revised system reduces Medicare payments to teaching hospitals for the cost of caring for the uninsured and disproportionate share of low-income patients because the need for such payments is greatly reduced with universal coverage.

Health plans are required to enter into contracts with eligible academic health centers to ensure access to specialized treatment for rare diseases and severe conditions. Additional funding is available to assist academic health centers with the establishment of referral and information systems in rural and underserved urban areas.

ACADEMIC HEALTH CENTERS:SUMMARY OF TITLE III, SUBTITLE B

ANNUAL ACADEMIC HEALTH CENTER ACCOUNT

A national account replaces the current Medicare payments for indirect medical education for costs over and above the routine costs of care, including research, development of new medical technology, treatment of rare and unusually severe illnesses, and specialized patient care.

The national account, set at $3.1 billion in 1996, will consists of medicare payments and contributions from regional and corporate alliances.

- The Secretary of the Department Health and Human Services transfers in 1996, $2.1 billion, and in 1997 and 1998 transfers $2 billion to the national account from the Medicare Trust Fund. In subsequent years, the Secretary estimates the percentage increases based on increase in the consumer price index for all urban consumers.

- Regional and corporate alliances reserves and contributes to the pool to make up the difference -- these funds come from an assessment of 1.5 percent of the total premiums collected by regional alliances and 1 percent corporate alliance payroll assessment.

Academic health center account distribution is based on:

- The annual academic health center account available for the calendar year.

- For each academic health center, the ratio of the number of residents to the number of beds, as well as total inpatient and outpatient net revenue.

ENSURING ACCESS TO ACADEMIC HEALTH CENTERS

To ensure that all patients receive the specialized services available through academic health centers when appropriate:

- The Department of Health and Human Services, in cooperation with states and health alliances, identifies rare disease, specialized procedures and treatments for which health plans are required to establish contractual relationships with academic health centers.

- Health alliances monitor contractual relationships between health plans and academic health centers to ensure enrollees receive appropriate specialized treatment expertise from such centers.

ENSURING RURAL AND URBAN ACCESS TO ACADEMIC HEALTH CENTERS

To secure appropriate access to academic health centers for patients in rural and urban areas with inadequate health care systems:

- Grants to academic health centers to assist in the development of an information and referral infrastructure to support rural health networks.

- The Secretary may make additional grants available to eligible centers to ensure access to residents of rural or urban underserved communities who other wise would not have adequate access to care.

ACCESS TO HEALTH CARE FOR UNDERSERVED POPULATIONS

OVERVIEW

In the existing health care system, major financial and non-financial barriers reduce access for a number of population groups in American society. Population groups that particularly confront barriers to care include:

- Low-income individuals.
- Residents of rural and urban underserved areas.
- Individuals who lack a stable residence, e.g. migrant workers and homeless individuals or families.
- Adolescents
- Individuals with severe health problems, e.g. AIDS, mental illness or serious disability.
- Members of certain racial, cultural and ethnic groups and those who speak languages other than English.

As a result, members of these population groups offer experience reduced health status and quality of life. Health care reform will significantly improve access to care by providing all Americans with comprehensive coverage for treatment services, clinical preventive services, mental health and substance abuse services.

Coverage alone will not eliminate barriers to care, however. In order to meet the obligation to provide comprehensive health care benefits, greater access to comprehensive health services for vulnerable population and communities will be needed.

Access initiatives remove barriers to care by:

- Increasing the supply of health professionals and delivery sites in underserved areas by helping community-based providers to form networks and plans.

- Expanding successful programs, such as community and migrant health centers.

- Assisting alliances and health plans reach out to vulnerable populations and deliver culturally sensitive care.

- Helping integrate providers supported through public funding with other providers in medically underserved areas.

*• Allowing communities the flexibility to improve access to care by building on existing resources and responding to local needs.

The issue of access is of paramount importance to rural and urban areas traditionally underserved by the health care system. Because both rural and underserved urban communities include large numbers of vulnerable residents, the Health Security Act will channel significant new resources into those communities to stabilize the economic base for health care.

ACCESS INITIATIVES: SUMMARY OF TITLE III, SUBTITLE E

The initiatives in this subtitle assure access to health services for urban and rural medically-underserved populations by expanding capacity and by supporting the provision of outreach and enabling services.

COMMUNITY AND MIGRANT HEALTH CENTERS

An additional $100 million is authorized annually from 1995 through 2000 to expand the Community and Migrant Health Center Programs and to permit health centers to establish financial reserves.

INITIATIVES FOR ACCESS TO HEALTH CARE

Two new federal grant and loan programs are established to provide medically-underserved populations with an adequate choice of community-oriented providers and health plans and to support activities that enable medically-underserved populations to access the health care system and use it effectively.

Development of Qualified Community Health Plans and Practice Networks

The Secretary of the Department of Health and Human Services makes grants and loans to consortia of public or private health care providers to develop community practice networks or community health plans. Categories of consortia providers eligible for assistance include the following:

- Doctors and other health professionals and health institutions (other than those below) providing care in areas with an inadequate supply of providers or to an underserved population.
- Community and migrant health centers.
- Homeless health providers and health care providers in public housing.
- Family planning clinics.

- Ryan White program providers.
- Providers delivering health services under the Maternal and Child Health Services Program.
- Rural health clinics and other federally qualified health centers;
- Providers delivering health services to Indians in urban areas under Title V of the Indian Health Care Improvement Act or outpatient services to Indians through the Indian Self-Determination Act.
- Providers delivering personal health services through State and local public health agencies.

In making awards, preference is given to consortia that include the maximum number of different types of relevant entities in an area and that link federally-funded providers with those not supported by public funds.

The Initiative integrates health professionals supported through public funding with other providers in medically underserved areas, bolstering their skills to coordinate care, negotiate effectively with health plans, and form their own health plans. Grants and loans under this program may be used to:

- Recruit, compensate, and train personnel.
- Acquire, expand, modernize, and convert outpatient and hospital facilities.
- Purchase major equipment.
- Acquire and develop information systems.
- Establish financial reserves.

As part of the agreements, networks and plans must show evidence of significant community involvement. In addition, once established they must:

- Assure that services are available to all persons seeking care, whether or not they are eligible to participate in the new system as outlined under Title I.
- Assure that providers are approved as Medicare and Medicaid providers.
- Prepare a fee schedule for uncovered services that is consistent with local rates and a schedule of discounts for low-income individuals.
- Maximize accessibility of services to residents in its area by eliminating barriers resulting from geographic or demographic characteristics, including limited ability of patients to speak English.

- Provide enabling services designed to assist patients and enhance access to care.

- Maintain ongoing systems for patient-oriented, community-responsive quality control, and for collecting and making public information on costs, health care and financial performance, and other matters.

For the development of community health plans and practice networks, the following amounts are authorized to be appropriated:

- $200 million for FY 1995
- $500 million for FY 1996
- $600 million for FY 1997
- $700 million for FY 1998
- $500 million for FY 1999
- $200 million for FY 2000

Enabling Services

This new program provides isolated, culturally diverse, hard-to-reach individuals not served by other programs with the supplemental services they need to obtain access to medical care and to use the health care system effectively.

Targeted grants are made to community health plans and practice networks described above, as well as other public or nonprofit entities allocated in underserved areas or that provide services to medically underserved populations and that are experienced in providing enabling and outreach services.

Grants cover transportation, community and patient outreach, patient education, translation, and other services that the Secretary determines will facilitate access to the services in the comprehensive benefits package.

Funds are authorized at $200 million in FY 1996, $300 million for each of FY 1997 through FY 1999 and $100 million for FY 2000.

NATIONAL HEALTH SERVICE CORPS (TITLE III, SUBTITLE E)

The National Health Services Corps increases the number of primary care practitioners in underserved rural and urban areas by five-fold by 2004 from current field strength of 1,600. A portion of the National Health Service Corps scholarships and loan repayments are reserved for nurses to increase to 20 percent the proportion of Corps members who are nurses.

Additional authorized appropriations total $50 million in FY 1995, $100 million in FY 1996, and $200 million from FY 1997 through FY 2000.

ESSENTIAL COMMUNITY PROVIDERS (TITLE I, SUBTITLE E,F)

The Secretary of the Department of Health and Human Services certifies essential community providers, a category of provider offered special protection and support in order to ensure that disadvantaged population groups receive adequate access to health care and support in making the transition to a competitive market. Organizations qualifying for automatic designation as essential community providers include:

- Migrant health centers
- Community health centers
- Homeless program providers
- Public housing providers
- Family planning clinics
- Indian Health programs
- AIDs providers under the Ryan White Act
- Maternal and Child Health providers
- Federally qualified health centers and rural health clinics
- Providers of school health services
- Community practice networks.

Individual health professionals, hospitals and other public or non-profit agencies that provide a substantial amount of care to medically underserved populations or in areas with a shortage of health professionals also may apply for designation as essential community providers.

Health plans enter into participation or payment agreements with all essential community providers who elect the arrangement most suitable to them. Under the participation agreement, health plans must extend to essential community providers participation in terms and conditions at least as favorable as given other providers.

In the absence of a participation agreement, health plans must pay essential community providers in accordance with either the alliance fee schedule or on the applicable Medicare payment methodology, at the election of the essential community providers.

School-based health providers are paid by health plans under a special arrangement, and the Secretary will determine an appropriate payment methodology in the future.

The essential community provider program begins the first year that any regional alliance health plan is offered. Five years after implementation, Congress decides whether or

not to extend the program. By March 2001, the Secretary of the Department of Health and Human Services prepares a study of whether, and to what extent, the essential community provider program should continue, including specific recommendations of where and what types of providers should remain covered.

PAYMENTS TO HOSPITALS (Title III, Subtitle E)

A new Vulnerable Population Adjustment Program is established as a transitional step to replace the Medicaid Disproportionate Share Hospital program, phasing in as states implement reform. States provide the Secretary with a list of qualifying hospitals. Once qualified, these hospitals remain eligible for payments for the full 5-year duration of the program, beginning in the first year of reform.

Qualifying hospitals (those that serve disproportionate number of low-income individuals) receive funding from this new program. The amount for each hospital is based on two factors:

- 25 percent is based on services not covered by the Act.
- 75 percent is based on the total number of low-income days attributable to the hospital.

Payments are made to eligible hospitals quarterly. Total allocation equals $800 million for each fiscal year.

MENTAL HEALTH & SUBSTANCE ABUSE PROGRAMS (TITLE III, SUBTITLE F)

As states implement reform, funding through the Community Mental Health and the Substance Abuse Prevention and Treatment formula grants is retained (for services not covered by the comprehensive national benefit).

The State System Development Program and Mental Health Statistics Improvement Program continues, along with prevention activities through the Substance Abuse Prevention and Treatment Program.

Authorized additional amounts distributed through formula grants total $100 million for FY 1995, $150 million for FY 1996, and $250 million each year from FY 1997 through FY 2000. The funds may be used for one or more of the following activities:

- Enabling services to low-income individuals or other population groups.

- Improvement of capacity to coordinate and monitor mental health and substance abuse services.

- Incentives to integrate public and private systems of treatment.

States maintain current support for mental health and substance abuse activities but may obtain waivers to develop community-based systems, promoting the integration of public and private treatment.

The Secretary makes available loans and loan guarantees to public and private entities for the development of non-acute, residential treatment centers and community-based ambulatory clinics. Projects in areas designated as having a shortage of health professionals receive priority.

By 1998, states submit a plan for the integration of the public mental health and substance abuse services. A pilot program to demonstrate model methods of integrating the systems is established.

COMPREHENSIVE SCHOOL-BASED HEALTH EDUCATION AND SCHOOL RELATED HEALTH SERVICES (TITLE III, SUBTITLE G)

Two new programs, administered by the Department of Health and Human Services in collaboration with the Department of Education, support comprehensive school health education and the delivery of school health services.

Comprehensive School-Based Health Education: Grants to state and local education agencies support comprehensive health education in grades K-12 in high risk schools.

The Secretary of Department of Health and Human Services and the Secretary of Department of Education may waive statutory and regulatory requirements for existing health education programs in order to pool funds to establish more effective and comprehensive school-based health education programs.

The curriculum is linked to Healthy People 2000 objectives and targets areas of health risk where research suggests that health education can reduce risk-taking behavior and improve health outcomes. Special emphasis is placed on problems specific to each local community.

Funds authorized to carry out this proposal is $50 million for each of the FY 1995 through FY 2000.

School Related Health Services: A new program targeted at high-risk youth ages 10-19 supports physical health and psychosocial services as well as counseling in disease prevention, health promotion, and individualized risk behavior reduction in school-based or school-linked sites.

Grants are available to states for the development and implementation of state-wide projects. In states that do not take this initiative, grants are available to local community partnerships including public schools, experienced providers, community organizations.

Providers funded under this program are automatically designated as essential community providers.

Grantees in both programs have the flexibility to determine health care services, health education programs, and delivery mechanisms based on assessment of community needs.

Funds for this program are in addition to any other funds authorized; authorized appropriation levels are appropriated from the Public Health Service Initiative Fund at a level of $100 million for FY 1996, $276 million for FY 1997, $350 million for FY 1998, and $400 million for FY 1999 and FY 2000.

SPECIAL FUND FOR WIC PROGRAM (TITLE VIII)

The Special Supplemental Food Program for Women, Infants and Children (WIC) receives additional amounts already authorized to fully fund the program.

HEALTH RESEARCH

OVERVIEW

Expanded investments in health research play an integral role in the Health Security Act. Research into the cost-effectiveness of clinical care and the appropriate use of new technologies aid in meeting the goals of quality improvement and cost control. Health research focus on common conditions, high-cost procedures, and the reasons for wide variations in how the same illness is treated in different areas.

- **Prevention research** into biomedical and behavioral aspects of health and disease, which serves as the foundation for clinical preventive services and public health interventions and reduces the burden of avoidable disease, disabilities, and death.

- **Health services research** related to the development of quality and outcome measures, access and financing and cost effectiveness, as well as research related to consumer choice and decision making, primary care and evaluation of health reform.

HEALTH RESEARCH INITIATIVES: SUMMARY OF (TITLE III, SUBTITLE C)

HEALTH PROMOTION AND DISEASE PREVENTION RESEARCH

Expanded investments in research focus on health promotion and disease prevention efforts which includes:

- Child and adolescent health.
- Chronic and recurrent health conditions.
- Reproductive health.
- Mental health.
- Elderly health.
- Substance abuse.
- Infectious diseases.
- Health and wellness promotion.
- Environmental health.

Special attention is given to research on Alzheimer's disease, breast cancer, heart disease and stroke, and birth defects.

Authorization levels are established at $400 million in FY-1995 and $500 million for FY-1995 through FY-2000. These funds are in addition to any other related authorizations.

HEALTH SERVICES RESEARCH

The Agency for Health Care Policy and Research of the Department of Health and Human Services supports and conducts research related to health care reform. Priorities include:

- Research on the appropriateness and effectiveness of alternative clinical strategies.
- The development, dissemination, and assessment of clinical practice guidelines.
- Quality and outcomes of care.
- Simplification of administration.
- Effects of reform on delivery systems.
- Consumer choice and information resources.
- Risk adjustment.
- Workplace injury.
- Access to care.
- Primary care.

Authorization levels are fixed at $150 million in FY 1995, $400 million for FY 1996, $500 million for FY 1997, and $600 million for each of FY 1998 through 2000. These funds are in addition to any other related authorizations.

CORE PUBLIC HEALTH PROGRAMS

OVERVIEW

The public health initiative repairs, strengthens and consolidates essential federal, state and local public health functions. In addition, it complements health reform through population–based prevention education and community mobilization.

The purposes of the core public health activities are to:

- Protect Americans against communicable diseases and exposure to toxic environmental pollutants, occupational hazards, harmful products, and poor quality health care.
- Identify and control outbreaks of infectious diseases and patterns of chronic diseases and injury.
- Inform and educate health care consumers and providers about their roles in preventing and controlling disease and appropriate use of medical services.

Dealing effectively with public health problems requires coordinated involvement among public health, community groups, alliances, and plans.

Health reform clears the way for the emphasis of public health activities to shift from the direct delivery of clinical health services to focus on prevention and health conditions that affect local communities.

CORE PUBLIC HEALTH PROGRAMS (TITLE III, PART D)

CORE PUBLIC HEALTH ACTIVITIES

The Secretary is authorized to make grants to state health agencies to undertake projects that will improve their ability to carry out one or more of the following essential public health functions at state and local levels:

- Data collection, surveillance of disease incidence and prevalence, and monitoring of health outcomes, to support accountability of the health care system and improve policy making and health care planning.
- Protection of communities from environmental hazards and assurance of safety of housing, work places, food and water.

- Investigation and control of infectious and communicable diseases and adverse health conditions.
- Public information and education, including community mobilization to address preventable risks to health.
- Accountability and quality assurance activities related to health and medical services.
- Public health laboratory services.
- Training and education of public health professionals.
- Leadership, policy development, and administration.

States apply for financial assistance to undertake these projects by stating clear, measurable objectives regarding health outcomes to be achieved and functional capability to be improved. They are also required to focus on improvements of local public health activities.

A small portion of funds available for support of core public health activities (no more than 5 percent) will be allocated for provision of federal expert assistance in epidemiology, biostatistics, and laboratory services and for development of an information network for diffusion of information among local, state, and national levels to strengthen public health nationwide.

Funds authorized to carry out this proposal are $12 million in FY 1995, $325 million in FY 1996, $450 million in FY 1997, $550 million in FY 1998, $650 million in FY 1999, and $750 million in FY 2000.

NATIONAL INITIATIVES REGARDING HEALTH PROMOTION AND DISEASE PREVENTION

This provision addresses health issues that affect whole communities and specific populations within communities. The Secretary makes grants to public or private not-for-profit agencies to undertake community-based projects to achieve the prevention agenda set forth in national goals and objectives (**Healthy People 2000**), including behavioral risks to health, physical and social environmental hazards, and the needs of certain populations for more appropriate utilization of clinical preventive services. The Secretary also sets annual priorities for project funding.

Among the initial set of priorities, the Secretary will support projects such as:

- Preventing the initiation of smoking by children and adolescents
- Preventing violence
- Reducing behavioral risks that contribute to the incidence of chronic diseases, including heart disease, cancer, stroke, and adult-onset diabetes

Projects may be supported for periods up to five years. Applicants must demonstrate the existence of high incidence/prevalence rates or high risk prevalence among the populations for whom their projects are designed. As effective community interventions from these projects are identified, information about them will be disseminated to facilitate their adoption by other communities.

Funds authorized to carry out this proposal are $175 million in FY 1996, and $200 million annually from FY 1997 through FY 2000.

MEDICARE

OVERVIEW

Since its inception, the Medicare program has offered older Americans and, since 1972 the disabled, the security of health care coverage. The Health Security Act continues current benefits unchanged, except for the addition of outpatient prescription drug coverage beginning January 1, 1996 and more choice of health plans.

Prescription Drugs: Prescription drugs are frequently the most cost-effective intervention to treat medical conditions. However, these potentially life-saving products are often inaccessible because of increases in costs and inadequate insurance coverage. Until very recently, prescription drug price increases dwarfed increases in the rest of the economy. Between 1980 and 1992, while the general inflation rate increased by 22 percent, drug prices increased 128 percent.

For older Americans and the disabled, the high cost of prescription drugs and heavy reliance on medications cause a significant financial burden. Medicare does not cover outpatient prescription drugs, and less than half of all drug costs for seniors are paid for by public or private insurance plans. As a result, prescription drug costs are the highest out-of-pocket medical costs for 3 out of 4 older Americans.

As the Medicare program expands its coverage, the program also becomes one of the world's largest purchaser of medication. With its market power, the program effectively receives discounts for prescription drugs currently on the market and gives the Secretary of Health and Human Services the authority to negotiate the price of new drugs for Medicare. This assures affordable coverage to all Medicare beneficiaries.

Additional Choice of Plans: Medicare beneficiaries interested in joining new health delivery systems, such as health maintenance organizations and preferred provider organizations, have a wider range of choices under an improved Medicare managed care program.

As health alliances form, Americans who become eligible for Medicare will have the option of continuing in many alliance health plans or enrolling in the Medicare program. Individuals eligible for Medicare who continue to work and their families obtain coverage through regional alliances. A Medicare beneficiary who is a spouse of a worker also receives coverage through the alliance.

Once states fully implement reform, they may elect to integrate the Medicare program into the alliance system. However, strict Federal requirements safeguard the benefits, financial liability, and choices of Medicare beneficiaries in states that undertake integration.

Slowing the Rate of Growth in Medicare: The Health Security Act commits the federal government to slowing the rate of growth in Medicare spending over the next decade.

To achieve that goal, the Act proposes specific changes to reduce the rate of growth of current program spending and redirect projected savings towards more direct benefits including new coverage for prescription drugs.

In the past, attempts to rein in double-digit rates of growth in both Medicare and Medicaid programs proved difficult -- to a large extent because they occurred outside the context of comprehensive health reform.

Outside the context of system-wide reform, reductions in the projected rate of growth of major public programs raise concerns about the access to care for Medicare beneficiaries. In the context of national reform, parallel reductions in growth in the public and private sectors are feasible without diminution of access. Certain changes that reduce the rate of growth in Medicare spending are appropriate in the context of reform.

- More Americans over age 65 who continue to work receive employer-paid insurance, reducing financial obligations in the Medicare program.

- Federal payments to hospitals that serve disproportionate number of low-income persons can be reduced in the context of reform.

MEDICARE: SUMMARY OF TITLE IV, SUBTITLE A AND TITLE II, SUBTITLE A

MEDICARE OUTPATIENT PRESCRIPTION DRUG BENEFIT

Two years after enactment but no later than January 1, 1996, the Medicare program expands to cover outpatient prescription drugs.

The Medicare drug benefit covers all drugs, biological products and insulin approved by the Food and Drug Administration (FDA). The benefit also covers drugs used in home infusion treatment. The Secretary of Health and Human Services may establish maximum quantities per prescription, may limit the number of refills and decide not to cover certain pharmaceutical products.

Medicare pays 80 percent of the cost of each prescription after a $250 annual deductible for each individual. Beneficiaries pay no more than $1,000 out-of-pocket in 1996. For brand name drugs, reimbursement is set at the lower of the actual charge, 90th percentile of actual charges in a previous period or the estimated acquisition cost plus dispensing fee.

For generic drugs, Medicare pays the lower of the pharmacist's actual charge or the median of the estimate acquisition costs all generic prices (times the number of units dispensed) plus a dispensing fee. The dispensing fee is $5 in 1996.

As with other Part B benefits, the Medicare prescription drug benefit is funded by both general federal revenues and premiums paid by beneficiaries. In addition to any normal annual increase in premiums, in the year that coverage for prescription drugs begins, the Part B premium increases to cover 25 percent of the cost of the new benefit -- approximately $11-a-month.

As a condition of participation in Medicare, drug manufacturers agree to pay quarterly rebates to the Medicare program based on the greater of 17 percent of the average manufacturer price or the difference between the average manufacturers price and the average non-retail price.

An additional rebate is required from any manufacturer who increases drug prices at a rate higher than inflation. If a manufacturer refuses to negotiate or the Secretary of the Department of Health and Human Services is unable to negotiate agreement, the Secretary may exclude the drug from Medicare coverage.

No rebate is required for generic drugs.

Under the Medicare rebate agreement, manufacturers of prescription pharmaceutical products must offer discounts to all purchasers on equal terms. Manufacturers are precluded from providing discounts to purchasers based solely on class of trade.

All pharmacists provide information to consumers regarding the appropriate use of prescription drugs, and potential interactions between medications.

MEDICARE AND THE ALLIANCE SYSTEM

State Integration: After a state fully implements reform, a request can be made to the Secretary of the Department of Health and Human Services to integrate Medicare beneficiaries into the alliance system with the assurance that:

- Medicare beneficiaries are assured of equal or better coverage.
- Financial liability for Medicare beneficiaries or the program does not increase.
- Each regional alliance offers at least one fee-for-service health plan that provides a benefit package at least as good as the Medicare benefit.

If only an enhanced benefit package is available, the cost to the beneficiary may not exceed the cost of the traditional Medicare benefit. Once integration occurs, federal spending for Medicare is limited to the pre-integration level of per-capita spending for each beneficiary adjusted by the state's regional alliances inflation factor for each year.

Individual Election to Continue in Alliance: When health alliances are established, newly eligible Medicare beneficiaries may remain in an alliance health plan that has a risk contract with the Medicare program or is eligible to enter into such a contract with Medicare.

Individuals who remain in alliance health plans continue to receive the nationally guaranteed comprehensive benefit package and pay the difference between the premium and the amount paid by Medicare. Medicare pays the amount that it would normally pay to a risk contractor. The health plan premium for beneficiaries is community-rated adjusted by a factor determined by the Secretary of the Department of Health and Human Services that reflects the difference in utilization between the Medicare beneficiaries and non-Medicare beneficiaries.

Medicare Secondary Payer: Medicare eligible individuals, or their spouses, who work more than 40 hours a month for two consecutive months with the expectation of working the third month receive coverage for themselves and their family members through the regional alliance system. Medicare continues, as it does today, as secondary payer to alliance health plans -- paying Part A cost sharing for all beneficiaries, and Parts A and B cost-sharing for Medicare beneficiaries who pay the Part B premium. In addition, Medicare pays the remainder of the employers share of the premium when a Medicare beneficiaries work part-time.

Medicare beneficiaries who stop working mid-year continue with their alliance health plan coverage until open-enrollment, with Medicare paying the employer share of the premium. During open-enrollment, the beneficiaries switches to Medicare coverage or elects alliance coverage under the individual election rules.

INCREASING OPTIONS FOR MEDICARE MANAGED CARE

The Medicare program establishes an annual open-enrollment period for Medicare managed care plans and Medigap plans, and provides informational material on the plans. It also authorizes the Secretary to establish point-of-service (POS) networks that beneficiaries may use to obtain care at reduced out-of-pocket costs. Medicare beneficiaries may elect to enroll in Medicare-approved HMOs, POS or to remain in traditional fee-for-service arrangement, with or without Medigap coverage.

MEDICAID

OVERVIEW

The Medicaid program was passed almost 30 years ago with the intent of ensuring health care coverage for the poor. Today, however, we find access to providers too limited for Medicaid recipients -- as providers that serve large number of Medicaid recipients find themselves financially disadvantaged, and consequently, reluctant to serve them.

Under the Health Security Act, access to care for Medicaid recipients improves as all Americans and legal residents, including those currently receiving Medicaid coverage, enter the alliance system to obtain the guaranteed comprehensive benefit package.

With reform, employed Medicaid recipients obtain coverage through alliances, just as other workers do. Former Medicaid recipients enroll in alliances, choose health plans and qualify for discounts based on income, like all other eligible individuals and families.

Individuals who qualify for Aid to Families with Dependent Children and Supplemental Security Income also enroll in health plans through regional alliances, choosing a health plan whose premium is at or below the weighted-average at no extra cost. The federal and state governments make premium payments for these individuals with the amount paid based on current state and federal Medicaid expenditures.

The federal and state governments pay an established, fixed rate for each person, replacing the existing program which reimburses providers on a fee-for-service basis at rates established by state Medicaid programs.

For low-income children under 19, a new wrap-around program is created to provide for services not included in the comprehensive benefits package, such as hearing aids and non-emergency transportation.

Medicaid coverage for institutional long-term care -- primary care in nursing homes -- continues with some improvements. The new community-based long-term care program for the severely disabled, which is a key component of the Health Security Act, reduces the financial burden by states as they provide long-term care services for severely disabled individuals.

The Medicaid program continues to supplement Medicare coverage for low-income individuals over age 65.

MEDICAID: SUMMARY OF TITLE IV, SUBTITLE C

All Medicaid recipients receive insurance coverage for the comprehensive benefit package through the alliances:

- Current Medicaid recipients who do not receive Aid to Families with Dependent Children or Supplemental Security Income receive coverage and discounts following the same rules and procedures as all other eligible individuals and families.

- The state and federal governments pay premiums to the appropriate regional alliance on behalf of recipients of cash assistance through Aid to Families with Dependent Children and Supplemental Security Income. Recipients receiving cash assistance can choose any plan at or below the average premium without making any premium payment. Further, if they choose a low cost-sharing plan, the cost-sharing is discounted to $2 for physician visit and from $5 to $1 for prescription drugs.

CONTINUATION OF SERVICES

Special services, such as transportation, outreach, and adult dental care continue for individuals and families who qualify for cash-assistance through AFDC and SSI.

Medicaid coverage for institutional care in nursing home continues largely unchanged . States may choose to increase the assets that individuals are allowed to retain when qualifying for Medicaid coverage for institutional care from $2,000 up to $12,000.

The personal needs allowance for institutionalized Medicaid recipients rise to $50-a-month for an individual and $100-a-month for an institutionalized couple. The federal government pays the difference between the amount a state currently allows (minimum of $30-per-month for an individual and $60-per-month for a couple) and the newly designated amount.

All states continue to have a medically needy program for institutional services.

PROGRAM FOR LOW-INCOME CHILDREN WITH SPECIAL NEEDS

A new federal program provides special services that are not covered under the nationally guaranteed comprehensive benefit package, such as hearing aids, non-emergency transportation, and therapies (e.g. speech therapy), for low-income children.

Children 18 and younger are eligible for the program. Financial eligibility is determined by current Medicaid eligibility rules. Services currently covered by Medicaid, but

not included in the comprehensive benefit package or through the current Medicaid long-term care program, are provided.

The Secretary of the Department of Health and Human Services implements this program, and expenditures are limited to the projected amount that would have been spent on these services in the absence of health care reform.

MEDICAID ADMINISTRATIVE SIMPLIFICATION

States implement changes in billing and claims processing rules for Medicaid no more than on a bi-annual basis.

States notify individuals and entities responsible for delivery of services at least 120 days before changes take into effect.

MEDICAID COMMISSION

A new 15 member commission is established to examine issues of relevance to further Medicaid reform -- use of block grants for covered services, integration of acute and long-term care services for health plans, consolidation of institutional and home and community-based long-term care, and other related services.

The commission reports its findings no later than one year after the enactment of the Health Security Act.

State Administration: To implement the program, each state must have an approved plan, which specifies:

- Administering agency or agencies.
- Services to be covered and how, overall, the needs of all types of eligible individuals will be met.
- How the state will deal with determining eligibility, developing care plans, coordinating services, reimbursing providers and plans, administering voucher/cash payments, licensing/certifying providers.
- How the state will allocate resources (including whether and how informal services will be taken into account).
- How the state will monitor, ensure, and improve service quality, including health and safety concerns.
- The composition and role of the state advisory group.
- How the new program will be integrated with existing long-term care programs. The plan also assures that the proportion of low-income people served in the new program is no less than the proportion of low-income people living in the state.

Quality Assurance: Under the new home and community-based service program, states are responsible for developing comprehensive quality assurance programs. States specify:

- How they will safeguard the health and safety of program beneficiaries.
- Minimum standards for agency providers.
- Minimum competency requirements for direct care staff.
- How all standards and requirements are enforced.

States must survey program participants to determine whether they received needed services and whether they are satisfied with such services. Consumer advisory groups play a strong role in planning, implementing and evaluating the program, and assuring and enhancing quality.

Advisory Groups: The President's plan require a federal advisory group for long--term care program, composed of a majority of individuals with disabilities and their representatives to advise on all aspect of the program. Similarly constituted groups are required to be involved in each participating state. In addition to a strong planning, implementing, oversight, and evaluation role, the group comments on the state plan, are a mandatory component of the plan.

Financing: The new home and community-based program is implemented over a seven-year period, beginning in fiscal year 1996.

- The Secretary of the Department of Health and Human Services establishes a national budget for the new program.

- After the program is fully implemented, the budget increases annually consistent with the rate of increase in the national health care budget and the number of persons with severe disabilities in the population.

- States are allotted a federal funding based on a formula that takes into account the number of persons with severe disabilities in their populations, average wages in the state, the age of the state's population and other factors..

- A combination of federal and state funds, plus copayments by individuals, finances the program. When fully phased in, the federal share of costs ranges from 78 percent to 95 percent. States pay the remainder of public costs between 5 percent and 22 percent of the total.

The federal share equals the total estimated cost for fully funding services for individuals with severe disabilities minus the amount spent on behalf of the eligible population by states under Medicaid and other home and community-based care programs, as well as co-payments.

States are prohibited from using other federal dollars to match the federal share. States may continue to provide home and community-based services under Medicaid, in addition to the new program.

Administrative Costs: The costs of administering the program including the eligibility determination process and care planning are included under the national budget. Differential federal administrative match rates will be established. At full phase-in, administrative costs are limited to 10 percent of each state's budget for this program.

CONTINUATION OF MEDICAID COVERAGE

In addition to the new home and community-based program, existing Medicaid community long-term care programs continue unchanged, including:

- Personal care
- Home and community-based waivers
- The frail elderly program
- Community Supported Living Arrangements
- Targeted case management
- The long-term care portions of Medicaid home health.
- Clinic services and rehabilitation services.

States must assure that individuals receiving Medicaid community-based long-term care services immediately prior to the enactment of the Health Security Act continue to receive an appropriate level of service after the new home and community-based service program is implemented.

States may elect to serve persons with severe disabilities under Medicaid, the new program, or both.

ELIGIBILITY IMPROVEMENTS FOR INSTITUTIONAL CARE

The Health Security Act improves coverage for institutional care under Medicaid by:

- Requiring states to establish a medically needy program for all residents of a nursing home or ICF/MR.

- Raising the living allowance for nursing homes and ICF/MR residents from $30 to $50 for an individual and $60 to $100 for an institutionalized couple.

- Offering states the option of allowing nursing home and ICF/MR residents to retain up to $12,000 in personal assets up from the current limit of $2,000 in determining eligibility for Medicaid coverage.

REFORM OF PRIVATE LONG-TERM CARE INSURANCE

Within two years of enactment, the Secretary of the Department of Health and Human Services promulgates federal standards for private long-term care insurance to enhance consumer protection, reduce the range of variations among policies and assure quality.

The Secretary also establishes a Long-Term Care Insurance Advisory Council to establish and monitor national standards and work toward the development of the private insurance market for long-term care.

The Secretary of the Department of Health and Human Services, after input from the Council, promulgates federal regulations for long-term care insurance offerings within two years of enactment of the Health Security Act. These regulations will include requirements for:

- Nonforfeiture of benefits in the event of policy lapse.
- Inflation protection.
- Certain pre-existing conditions provisions.
- Third party notification of pending lapse under some circumstances.
- Definition of services and eligibility.

Federal regulations are applied to long-term care insurance business practices, including:

- A requirement for a state appeals process
- Complaint resolution procedures.
- Training and certification of agents, with limits on their commissions.
- Requirements for premium approval and pricing assumptions.
- Prohibitions against improper sales practices.

States enforce national standards, qualifying for federal grants for implementation based on a plan submitted to the Secretary. If a state fails to submit an adequate plan, it is not eligible for federal implementation grants and no long-term care insurance may be sold in that state until it acts.

TAX TREATMENT OF LONG-TERM CARE INSURANCE

Tax incentives encourage consumers to purchase private long-term care insurance. The Health Security Act amends the Internal Revenue Code to:

- Exclude from taxable income amounts paid toward a qualified long-term care policy.

- A maximum daily benefit established for a base year with annual adjustments based on increases in the wage price index or an alternative selected by the Treasury Department in consultation with the Department of Health and Human Services.

- Define medical expenses to include qualified long-term care services.

- Include the cost of qualified long-term care policies as itemized medical expense deductions.

- Treat employer-paid premiums for long-term care insurance as deductions for employers and excluded from taxable income for employees.

TAX INCENTIVES FOR INDIVIDUALS WITH DISABILITIES WHO WORK (TITLE II, SUBTITLE B; TITLE VII)

Employed individuals who require assistance with activities of daily living and who purchase personal care and personal assistance may claim a tax credit of up to 50 percent of their costs up to $15,000 per year. The maximum annual tax credit is the lesser of 50 percent of the taxpayer's earned income or $7,500.

Taxpayers who claim the tax credit for a particular expense are not allowed to claim an itemized deduction for the same expense. The credit is reduced for taxpayers with adjusted gross incomes between $50,000 and $70,000; those with adjusted gross incomes in excess of $70,000 are not eligible. The proposal becomes effective for expenses incurred after Dec. 31, 1995.

ACUTE/LONG-TERM CARE INTEGRATION DEMONSTRATIONS

The Secretary of the Department of Health and Human Services conducts a demonstration program for integrated models of acute and long-term care services for individuals with disabilities and chronic illnesses. The demonstrations define integration models, assess their viability, evaluate impact, and determine the appropriateness of such models in the managed competition structure. The Secretary sets minimum benefit specifications and ensure that model sites include comprehensive medical benefits, specialized transitional benefits, and other long-term care benefits, or specialized habilitation services for participants with developmental disabilities.

Demonstration sponsors provide enrollment services, client assessment and care planning, simplified access to services, ongoing integrated acute and chronic care management, continuity of care across settings and services, quality assurance, grievance and appeal procedures, member services and strong consumer participation.

LONG-TERM CARE SYSTEM PERFORMANCE REVIEW

The President's plan includes a provision for an overall performance review of all the components of the long-term care proposal. The review covers quality, access, and availability of long-term care supports for people with disabilities. The Secretary of the Department of Health and Human Service will submit interim and final reports to Congress.

VI. QUALITY

QUALITY AND CONSUMER PROTECTION

OVERVIEW

Many Americans worry that strong action to restrain costs will compromise the quality of health care. The goal of the Health Security Act is to build attention to quality into all levels of health care. To that end, a national quality management program creates performance measures focused on continuous improvement.

Traditional quality assurance depends on after–the–fact checks, relying primarily on external reviews, forms and process checks. Insurance companies, peer review organizations, state and federal regulatory agencies audit the work of hospitals, professional offices, clinics and laboratories, searching for infractions and punishing rule breakers.

Patients play a minor role, lacking reliable information to compare treatment options or the quality of health plans and providers. Yet rational choice among treatments depends on shared decisionmaking between physician and patient.

The Health Security Act provides the professions with resources they need to improve quality in the Nations's health care system. Patient–focused continuous improvement raises quality by improving the outcomes of care and assuring that patient needs are met. A sophisticated information system utilizing routinely collected data provides concrete measures of performance. It reports the performance of health plans on such measures as the rate of survival among patients who suffer heart attacks, the number of children who receive immunizations, the number of new mothers who receive prenatal care, and the level of patient satisfaction with the plan. The quality management program delivers useful information to consumers through annual performance reports on health plans and providers.

QUALITY AND CONSUMER PROTECTION:SUMMARY OF TITLE V, SUBTITLE A

NATIONAL QUALITY MANAGEMENT COUNCIL

The Health Security Act establishes a national quality management program overseen by the National Quality Management Council. The Council consists of 15 members including representatives of consumer groups, health plans, states, purchasers of care and experts in publish health and quality of care. The Council sets national goals for performance on selected quality measures and evaluates the impact of reform on the quality of health care and access to services.

PERFORMANCE REPORTS

The National Quality Management Council develops a core set of quality and performance measures and updates them over time. It reports annually to Congress on the performance of each regional and corporate alliance and health plans on those measures and reviews state and national quality trends. Each health alliance also makes available to the public a performance report that includes the performance of each health plan offered in the alliance.

Performance reports include information on access to care, appropriateness of care, health outcomes, health promotion, disease prevention and satisfaction with care. The reports provide information on a subset of measures for health care institutions, doctors and other practitioners if the available information is statistically meaningful.

CONSUMER SURVEYS

The National Quality Management Council conducts periodic surveys of consumers to gather information about access to care, use of health services, health outcomes and patient satisfaction. It disseminates its findings and includes the results in annual performance reports.

CLINICAL PRACTICE GUIDELINES

The National Quality Management Council directs the Administrator for Health Care Policy and Research to: develop and periodically review clinical practice guidelines that may be used by health care providers to assist in the prevention, diagnosis, and treatment of disease; oversee a clearing house and dissemination program for practice guidelines; develop standards relating to the methodologies for developing guidelines; and establish a procedure by which entities may have guidelines evaluated and certified in accordance with the standards developed.

THE KNOWLEDGE BASE TO IMPROVE QUALITY OF CARE

The National Quality Management Council disseminates information documenting clinically ineffective treatments and procedures. The Council establishes priorities for research with respect to the quality, appropriateness and effectiveness of health care and make recommendations concerning research projects. It also supports research related to the development of performance measures.

REGIONAL PROFESSIONAL FOUNDATIONS

Representatives of academic health centers, schools of public health, health professional schools, health plans, alliances and providers form private non-profit regional professional foundations across the United States. The regional professional foundations:

- Develop programs in lifelong learning for health professionals to ensure the delivery of quality care.
- Foster collaboration among health plans and providers to improve quality.
- Disseminate information about successful quality improvement programs, practice guidelines, innovative uses of health professionals and research findings.
- Develop patient education programs that promote patient involvement in treatment decisions.

NATIONAL QUALITY CONSORTIUM

A National Quality Consortium oversees and advises the National Quality Management Council and Regional Professional Foundations:

- Establishes programs for continuing education for health professionals.
- Advises the Council and the Agency for Health Care Policy Research on priorities.
- Consults with the National Quality Management Council on the selection of national measures of quality performance.
- Oversees the development of Regional Professional Foundations.
- Advises the National Health Board.

ROLE OF ALLIANCES

Regional and corporate alliances:

- Ensure through negotiations that health plans pursue continuous improvement in their performance on national quality outcome measures.
- Disseminate to consumers annual performance reports for each health plan, the results of consumer-satisfaction surveys and other information.

- Conduct educational programs through regional quality foundations to assist consumers in using quality information in choosing health plans.

ROLE OF HEALTH PLANS

Each competing health plan measures and discloses information related to performance on quality measures required by participating states, regional and corporate alliances and the National Quality Management Council

ELIMINATION OF SELECTED CLIA REQUIREMENT

The need for a certificate of waiver for simple laboratory examinations and procedures required under the Clinical Laboratories Inspection Act is repealed for laboratories that perform only such procedures.

Although not formally part of the Health Security Act, there will be additional streamlining of CLIA through regulation.

UNIFORM STANDARDS FOR HEALTH CARE INSTITUTIONS

Within three years of enactment the National Health Board develops uniform standards for licensing health care institutions that address essential performance requirements relating to patient care except in the areas of fire, safety, sanitation and patient rights. Standards must not undermine nursing home reform. Demonstration projects are completed by January 1, 1996. Standards, once tested and revised, replaces existing standards except where changes in Federal statutes are required. The Council also undertakes efforts to develop a single consolidated audit and inspection.

HEALTH INFORMATION SYSTEMS, PRIVACY PROTECTION, AND ADMINISTRATIVE SIMPLIFICATION

OVERVIEW

Health Information Systems: Quality improvement depends on information that is useful to consumers and providers. The Health Security Act envisions a national information system that will simplify the administration of health coverage, support quality improvement and protect the privacy of patients. Using standard forms, uniform data sets, electronic networks and national standards for electronic data transmission, the new information system is built on these principles:

- Protection of privacy and confidentiality.
- Partnerships between the public and private sectors.
- National standards for clinical and administrative information.
- Appropriate links to the information infrastructure programs.
- Electronic transfer of data to ensure the timely availability of reliable information.

The health care information system focuses on the production of useful comparative information on health plans and providers, analysis of outcomes and patterns of care to support health providers and evaluation of the health care system.

Protection of Privacy: The Health Security Act institutes critical safeguards to protect the privacy, security and confidentiality of patient records, including:

- The establishment of a national privacy framework and safeguards.
- New mechanisms of enforcement.
- A system of universal identification numbers.
- Security standards.

Administrative Simplification: To correct waste and inefficiency caused by excessive administrative burden, the Health Security Act calls for the adoption of standard forms for routine transactions in the health care system, both financial and clinical. In addition, the Health Security Act envisions an era in which government regulations and inspections of health care institutions carry out their vital mission of protection without overburdening doctors, nurses, clinics and hospitals. To that end, the National Health Board develops:

- Standard forms to record enrollment, clinical encounters and insurance reimbursement.
- Automation of insurance transactions and industry-wide adoption of standard forms.
- Simplified systems for coordination of benefits.
- "Standard and unique" identification numbers for all health care providers, health plans, employers and enrolled consumers.
- The Medicare program steps up efforts to streamline its administration.

HEALTH INFORMATION SYSTEMS

ESTABLISHMENT OF HEALTH INFORMATION SYSTEM (TITLE V, SUBTITLE B)

The National Health Board establishes a health information system governing the collection, reporting and dissemination of health care information.

Information collected are used for the following purposes:

- Health care planning, policy development and evaluation, research.
- Establishing and monitoring payments for health services
- Assessing and improving the quality of health care
- Measuring and improving access to health care
- Evaluating the cost of clinical or administrative functions
- Supporting public health functions and objectives
- Improving the capacity of health plans, providers and consumers to improve and make choices about health care.
- Managing and containing costs at the plan and alliance level.

Health care information to be collected includes:

- Enrollment and disenrollment in health plans, on clinical encounters and other items and services provided by health care providers, and administrative and financial transactions.

- The characteristics of populations in regional and corporate health alliances and terms of agreement between plans and providers.

- Payment of benefits, utilization management, quality management, and such other information as the Board determines.

The health care information system is developed in consultation with federal agencies, states, alliances, health plans, representatives of health care providers, employers, consumers, experts in public health and health care information and technology, and representatives of organizations furnishing health care supplies, services and equipment.

The National Health Board determines the form, manner, content and frequency of information to be reported to the system. In addition, the Board establishes standards for paper forms, uniform health data sets, and electronic data interchange. In general, data standards issued by the Board preempt state law.

ESTABLISHMENT OF ELECTRONIC DATA NETWORK

As part of the health information system, the National Health Board oversees the establishment of an electronic data network consisting of regional data centers which electronically link plans, alliances, states and the federal government for the purpose of exchanging information.

The electronic data network is developed in consultation with federal agencies, states, the National Quality Management Program, regional and corporate alliances, and health plans. Implementation of the network is preceded by adequate demonstration and testing activities.

HEALTH SECURITY CARD

The National Health Board establishes the form and standard content of Health Security cards issued to eligible individuals.

Each health plan, health provider, employer and eligible individual is assigned a unique identification number that assures ready access to basic identification and enrollment information.

PRIVACY AND SECURITY OF HEALTH INFORMATION

OVERVIEW

Individually identifiable health information poses a dilemma for health care reform: accurate, timely data is essential to delivering the highest quality and most efficient care, yet information about a person's medical history is among the most sensitive information our society maintains.

Today, no comprehensive privacy standards for health information exist. Legal protection of this information is primarily left to state laws which provide varying degrees of protection. These protections are no longer adequate due to the growing movement of information (often in electronic form), and of individuals and organizations, across state lines.

The Health Security Act emphasizes the importance of protecting patient privacy while sharing information among the National Health Board, health alliances, and accountable health plans and for other permitted health system purposes.

National Privacy Standards

- No later than two years after the enactment of the Health Security Act, the National Health Board establishes national privacy safeguards that cover individually identifiable records generated by the new health system.

- Within three years, the National Health Board develops a detailed proposal for legislation to provide a comprehensive scheme of federal privacy protection for all individually identifiable health information (whether or not they are part of the new health care system and regardless of the form in which these records are kept).

Principles Protecting Patient Rights

- The new privacy safeguard requires the informed consent of persons regarding the use of personal data, grants persons the right to know how data about them is used, grants persons the right to review and correct personal data, and limits the use of data.

- Where disclosure of information is made to law enforcement officials for enforcement of the Act, the minimum amount of information necessary to accomplish required purposes is disclosed.

- The National Board is given the authority to:

- Conduct research relating to the privacy and security of individually identifiable health information.

- Develop technology for implementing security standards.

- Develop consent forms governing disclosure of information.

Health Data Protected from Other Uses

- The Health Security Act prohibits the use of the health security card except for the purposes of obtaining the services in the guaranteed national benefit package.

- Data collected as part of the operation of the new health care system is used only for that purpose, and may not shared with any other entity.

- Individually identifiable health care information may not be used as a basis for employment decisions.

ADMINISTRATIVE SIMPLIFICATION

INTERIM REQUIREMENTS FOR ADMINISTRATIVE SIMPLIFICATION

Within one year of enactment, the Board promulgates and publishes standard forms to simplify administration of health care, including insurance claims forms, enrollment forms, and records of clinical encounters. Health providers and plans use standard forms developed by the Board.

REMEDIES AND ENFORCEMENT: SUMMARY OF TITLE V, SUBTITLE C

OVERVIEW

Enrollees or providers whose claims for benefits or payment, or whose request for preauthorization of items or services are denied or delayed, are entitled to appropriate redress, under an administrative review system overseen by the Department of Labor. Determination is made in accordance with the rules an decisions of the National Health Board, and with other requirement of the Health Security Act.

HEALTH PLAN DETERMINATIONS

- Health plan reconsiders any denial upon request: A claimant has 60 days from receipt of a denial to request reconsideration from the plan.

- Health plan makes timely decisions: A plan provides written notice of its decisions within 30 days of submission of the claim or request for reconsideration. In the case of claims involving an urgent health need, a health plan has 24 hours to respond.

STATE ADMINISTRATIVE APPEALS: COMPLAINT REVIEW OFFICE

Each state establishes a complaint review office for each regional alliance to handle appeals from regional and corporate alliance health plans.

Regional Alliance Claimants

After completing the internal health plan review process, persons with claims against regional alliance health plans can elect to submit the claim to a hearing in the complaint review office, to suspend that hearing while pursuing an early resolution program, or to take the claim directly to court.

- **Early Resolution:** Each state establishes an Early Resolution Program in each of its complaint review offices. The Program includes mediation and other types of alternative dispute resolution (including binding arbitration) as may be prescribed by regulations. The findings of the dispute facilitator are nonbiding, except that settlement agreements signed as a result of mediation are binding contracts.

- **Hearings:** Hearing officers are provided with the following arsenal of remedies: cease and desist orders; orders to provide benefits due and to comply with the terms of a health plan and those established in the Act; and in situations in which a claimant prevails, officers may award prejudgment interest on actual costs, attorney's and witness fees are available.

- **Court:** If a claimant chooses to forego the above, a law suit may be brought in any court of competent jurisdiction.

Corporate Alliance Claimant

Persons with claims against corporate alliance health plans can elect to submit the claim to a hearing in the complaint review office, or to suspend that hearing while pursuing an early resolution program.

FEDERAL ADMINISTRATIVE APPEALS: FEDERAL HEALTH PLAN REVIEW BOARD

The Department of Labor appoints the Federal Health Plan Review Board, a five-member administrative appeals board, and establish the procedural rules for this panel. The National Health Board has the right to intervene in its proceedings.

- Review by the Federal Health Plan Review Board is not review de novo. The panel determines whether the state administrative determination is appropriately supported by the administrative record, whether the determination is in excess of the state review officer's jurisdiction, and whether required procedures were followed.

- The prevailing complainant is entitled to reasonable costs and expenses, including reasonable attorney's fees.

FEDERAL COURT OF APPEALS

A person may appeal a decision of the Federal Health Plan Review Board to the United States Court of Appeals, if the value of the claim exceeds $10,000.

- Appeals must be filed within 60 days of the entry of the Federal Health Plan Review Board's final order.

- The prevailing complaint is entitled to reasonable costs and expenses, including reasonable attorney's fees.

EXPEDITED PROCEDURES FOR EMERGENCY PREAUTHORIZATIONS

Where preauthorization for urgently needed is requested, the Health Security Act provides for expedited procedures for true medical emergencies that are not subject to prior authorization.

MEDICAL MALPRACTICE

OVERVIEW

The Health Security Act represents the first national attempt to address malpractice simultaneously on several fronts, including changes in tort reform, mandatory alternative dispute resolution, and encouragement of innovative approaches to liability issues.

It initiates increased emphasis on alternative approaches to dispute resolution, requiring health plans and alliances to provide aggrieved patients with several potential vehicles for resolving their complaint short of pursuing action in court. Before going to court, it asks patients to submit their case to an objective qualified specialists for review, requiring another health professional to attest that its handling fell outside normal practice and treatment protocols.

Through a sliding scale based on the level of award, reform limits the level of contingency fees that attorneys who represent aggrieved patients can collect to a maximum of 33 percent.

The Act also launches demonstration project to test the value of two innovations in basic approach to medical malpractice: enterprise liability, through which health plans and institutions rather than individual providers assume liability, and the use of practice guidelines as objective criteria against which care is measured.

Each component of malpractice reform has been implemented at the state level although on a limited basis. However, no state has adopted the full array of approaches in tandem, attempting to address the complex problem of medical malpractice from a number of angles.

MALPRACTICE REFORM: SUMMARY OF TITLE V, SUBTITLE D

Federal tort reform applies to any medical malpractice liability action brought either to federal or state court, with the exception of a claim or action for damages resulting from a vaccine-related injury or death.

Alternative Dispute Resolution (ADR)

- Each health plan establishes an alternative dispute resolution process using one or more of the models developed by the National Board. The Board is required to develop at least three ADR methods: arbitration, mediation, and early offers of settlement.

- No malpractice claim arising from health care provided (or not provided) in a regional alliance or corporate alliance health can be brought in court until final resolution is made by the plan's alternative dispute resolution process.

- Once the plan's alternative dispute resolution process is complete, a plan enrollee dissatisfied with the result may bring a cause of action in court, to the extent otherwise permitted by state law.

Tort Reform

- Before going to court, patients obtain a written certificate of merit from a qualified medical specialist. The specialist must review the medical record and other materials, and find that there is a reasonable and meritorious cause for bringing the legal action.

- Attorney's contingency fees are limits to one third of the total amount awarded to the plaintiff.

- The total amount of damages awarded to a plaintiff must be reduced by any amounts the plaintiff recovers from collateral sources (i.e., disability insurance, health insurance, wage continuation programs, etc) for the same injuries.

- Either party to the malpractice action may request that the award by paid in periodic installments.

Demonstration of Innovative Approaches

- By January 1, 1996, the Secretary of the Department of Health and Human Services provides funds to one or more states to establish demonstration projects to test whether substituting health plan liability for the personal liability of the physician will improve the quality of care, reduce defensive medicine, improve risk management.

- Not more than one year after appropriate practice guidelines exist, the Secretary of the Department of Health and Human Services must provide funds to one or more states to establish pilot programs to determine the effect of using practice guidelines as a complete defense to malpractice liability actions.

FRAUD AND ABUSE

OVERVIEW

Through comprehensive reform, the Health Security Act reduces opportunity for fraud and abuse in the delivery of health care. In addition, the Act creates authorities specifically to fight and discourage fraud and abuse.

The entire structure and key provisions of the reform package itself reduce opportunities and incentives for fraud and waste. For example, the creation of uniform health benefits reduces opportunities for fraud and abuse related to coverage. Establishing a uniform system of employer-sponsored health coverage reduces the complex coordination of benefits, multiple billing and exclusions in the current system. Putting providers and plans at financial risk for the costs of care reduce incentives for abuse, particularly the delivery of excessive tests and manipulation of coding and billing procedures.

Reductions in the complexity of payment procedures, including administrative simplification, adoption of standard forms, and uniform codes for insurance transactions minimizes the potential for fraud and abuse.

The adoption of unique identification numbers for health providers, plans, employers and consumers -- protected by strong privacy and confidentiality safeguards -- and the establishment of standards for the collection and use of electronic data reduce the potential for gaming the system through false claims.

Complementing these inherent fraud reducing features, the Health Security Act provides a battery of new tools explicitly targeted on fraud.

FRAUD AND ABUSE CONTROL PROGRAM (TITLE V, SUBTITLE E)

The Secretary of the Department of Health and Human Services and the Attorney General coordinate federal, state, and local law enforcement activities to reduce health care fraud and abuse. They conduct and coordinate audits, civil and criminal investigations, inspections, and evaluations relating to health care. They have access, for official purposes, to all records available to health alliances and health plans that relate to the program.

A new All-Payer Health Care Fraud and Abuse Control Account becomes the repository of proceeds from criminal and civil fines, penalties, forfeitures, and damages collected as a result of the investigation and prosecution of health care fraud. The account funds additional investigative and enforcement activities, as well as evaluation of any vulnerabilities in the new system.

KICKBACKS AND PHYSICIAN SELF-REFERRALS (TITLE IV, SUBTITLE A)

Payment in exchange for referral of medical services, which is now illegal under Medicare and Medicaid, is unlawful for all health care providers. A new civil monetary penalty is created for all such kickback violations, and the current exclusion from Medicare and Medicaid is expanded to include all payers. However, exceptions are allowed to ensure access to care and to promote economy and efficiency, especially in managed care programs.

Similarly, rules which now prohibit Medicare and Medicaid payment for services when the referring physician has a financial relationship in them is expanded to all payers. Furthermore, the list of designated health services subject to the ban is expanded to include any item or service not rendered by the physician personally or by a person under the physician's direct supervision. Many exceptions are allowed, however, such as for certain in-office ancillary services, and with respect to prepaid plans or capitated services.

CIVIL AND CRIMINAL PENALTIES (TITLE V, SUBTITLE E)

New health care fraud criminal statutes are created. Key provisions include:

General Health Fraud. A new general health care fraud statue, modelled on the current mail fraud laws, outlawing schemes to defraud any health plan, alliance, or individual.

False Statements. Prohibition of false statements in any matter involving a health alliance or a health plan;

Bribery. Prohibition of the bribing of officials of health alliances, health plans, entities that provide services under contract to alliances or plans, state agencies having regulatory authority over a health alliance or health plan, or health care sponsors;

Injunctions. Injunctive relief in all cases involving Federal health care offenses;

Grand Jury Disclosure. Authority to use grand jury information concerning a health law violation for use in a civil proceeding related to a Federal health care offense;

Theft. Prohibition of theft or embezzlement of moneys or other assets of a health alliance, health plan, or fund connected with such alliance or plan;

Health Security Card. Prohibition of the misuse of health security cards or unique identifier numbers; and

Forfeiture. Authority to provide for court ordered forfeiture in cases involving certain egregious Federal health care fraud offenses.

CIVIL AND ADMINISTRATIVE PENALTIES (TITLES IV AND V)

The civil False Claims Act is expanded to cover claims presented to all health plans, not just government funded plans as is now the case.

New administrative civil monetary penalties applicable to all payers are created. Many of these penalties are similar to those which now apply to Medicare and Medicaid. But there are also some new ones which reflect important new features of the overall health reform proposal. Penalties of $10,000 or $50,000, depending on the severity of the offense, can be taken for false claims, false statements, and specified actions by plans, such as:

Denying enrollment: Expelling or refusing to re-enroll an individual.

Insufficient Care: Failing substantially to provide or authorize medically necessary items or services that are required to be provided to an individual.

Misrepresentation: Engaging in any practice to induce enrollment in a health plan through misrepresentations.

The Secretary of Health and Human Services initiates these civil monetary penalties. With approval from the Departments of Justice and Health and Human Services, the Department of Labor or a State can also initiate an action under this section for actions relating to a corporate alliance health plan or a regional alliance health plan, respectively.

EXCLUSIONS (TITLES IV AND V)

Health care providers who commit fraud or abuse health care programs or patients can be administratively excluded from participation in all health plans. Many of the bases for exclusion are similar to the current bases for exclusion from Medicare and Medicaid, such as:

Patient Abuse Conviction: Criminal conviction for patient abuse.

Fraud and Financial Misconduct Conviction: Criminal conviction relating to fraud or other financial misconduct in connection with the delivery of a health care item or service.

Loss of License: Revocation or loss of license (or surrender during formal disciplinary proceeding) to provide health care for reasons of professional competence, performance or financial integrity.

Drug Conviction: Criminal conviction related to a controlled substance.

ANTI-TRUST REFORM

OVERVIEW

Today, the McCarran-Ferguson Act, grants a broad antitrust exemption to the business of insurance to the extent that such business is regulated by state law (boycotts remain unlawful). The state law which triggers this exemption need not be related to anti-trust; courts have found almost any form of state regulation to be sufficient.

The Health Security Act repeals this exemption, and also gives antitrust protection for certain collective provider negotiations.

MCCARRAN-FERGUSON REFORM (TITLE V, SUBTITLE F)

The Health Security Act repeals the McCarran-Ferguson exemption for the business of insurance to the extent that the business relates to the provision of health benefits. The repeal becomes effective on the first day of the sixth month after the date of enactment.

PROTECTION FOR CERTAIN COLLECTIVE NEGOTIATIONS: SUMMARY OF CERTAIN SECTIONS IN TITLE I, SUBTITLE D, § 1322

Anti-trust protection for providers allow them to collectively negotiate the fee-for-service fee schedule with the regional alliance.

In addition, collective negotiations are considered as efforts intended to influence governmental action. This brings these negotiations under the protection of existing anti-trust case law which describes an anti-trust immunity for such efforts.

The establishment of the regional alliance fee schedule is treated as state action, providing further protection for negotiations between regional alliances and providers.

Boycotts, and threats to boycott, are excluded from the above protections. Such actions will be subject to anti-trust scrutiny just as they are today.

VII. OTHER GOVERNMENT PROGRAMS

HEALTH PROGRAMS OF THE FEDERAL GOVERNMENT

OVERVIEW

The Federal government operates an array of health programs that serve its employees, military personnel and retirees, veterans and American Indians. In order to tailor health reform to the needs of each of those constituents, it is essential to design a unique approach to each individual agency taking into consideration its mission, history and organization.

Under provisions laid out in the Health Security Act, each relevant Federal agency approaches health care reform on its own terms, setting a course that fulfills its commitments to current and future beneficiaries:

- The Department of Defense may create military health plans based around military hospitals in the United States. If plans are organized, active duty military will enroll and current CHAMPUS beneficiaries may choose to enroll in military health plans.

- The Department of Veterans Affairs creates veterans health plans offered through regional alliances in areas served by VA hospitals. All veterans are eligible to enroll in VA health plans,and certain veterans such as those with service connected disabilities and low-income veterans have first priority to enroll. The VA also continues to provide other services, such as long-term care.

- Individuals and families covered under the Federal Employee Health Benefit Program enroll in regional alliance health plans located where they live on January 1, 1998.

- The Indian Health Service continues to operate its clinics and hospitals as separate programs, and it may act as a health provider that contracts with health plans. Individuals eligible for coverage choose whether to receive care through the Indian Health Service or to enroll in a regional health alliance.

DEPARTMENT OF DEFENSE: SUMMARY OF TITLE VIII

The Secretary of Defense may establish one or more Uniformed Services Health Plans. Uniformed Services Health Plans conform, to the maximum extent practicable, to other requirements for health plans under the Health Security Act and must provide the comprehensive benefit package. In addition, a Uniformed Services Health Plan guarantees to members of the uniformed services on active duty for longer than 30 days as of December 31, 1994 and other covered beneficiaries as of that date all services and benefits to which they are entitled under current programs.

Each member of a uniformed service on active duty for a period of more than 30 days must enroll in a Uniformed Services Health Plan. Other individuals given subsequent priority for enrollment are:

- Spouses and children of members of the uniformed services.
- Military retirees.

An active-duty member enrolled in a Uniformed Services Health Plan pays no premiums or cost sharing other than subsistence charges. Spouses and children of active-duty members and retirees pay the family share of premiums and cost sharing. Payments in 1995 may not be higher than the lesser of the out-of-pocket costs owed by these individuals on December 31, 1994 and the amount charged by other health plans. The limitation on out-of-pocket costs may be adjusted by an appropriate economic index after 1995.

An individual who is eligible to enroll in a Uniformed Services Health Plan but chooses not to enroll may not receive services through military health facilities.
If an individual eligible to enroll in a Uniformed Services Health Plan enrolls in another alliance health plan, the Secretary may make a premium payment on behalf of the eligible individual.

If a person eligible for Medicare Part B enrolls in a Uniformed Services Health Plan, Medicare makes a premium payment on behalf of the individual.

DEPARTMENT OF VETERANS AFFAIRS: SUMMARY OF TITLE VIII

The Secretary of Veterans Affairs organizes health plans as defined under the Health Security Act. VA health centers within a geographic region may organize to operate as a single health plan or as several health plans.

Any veteran may enroll in a health plan offered by the Department of Veterans Affairs, as may individuals eligible for CHAMPVA. The Secretary may authorize a VA health plan to enroll family members of veterans and may charge premiums and cost sharing. VA health plans provide the nationally guaranteed, comprehensive benefit package. In addition, the VA continues to provide additional care and services currently provided under chapter 17. The Secretary may also offer supplemental health services and charge a premium to cover the costs.

The following veterans who enroll in VA health plans do not pay premiums or cost sharing:

- Veterans with service-connected disabilities.
- Veterans discharged from the active-duty military, naval or air service because of a service-connected disability.
- Veterans who are former prisoners of war, veterans of the Mexican border period or World War I.
- Low-income veterans.

Other veterans and individuals who are not veterans enrolled in VA health plans pay premiums and cost sharing. The Secretary of Health and Human Services enters into an agreement with a VA health plan or medical center that applies to participate in the Medicare program. Medicare reimburses VA health plans on the same basis as it pays other providers.

A VA health plan may provide care to veterans enrolled in non-VA health plans if the VA is reimbursed for the cost.

The Secretary of Veterans Affairs may enter into a contract for the provision of services by a VA health plan if the Secretary determines that contracting is more cost effective than providing direct care or is necessary because of geographic inaccessibility.

The Secretary of Veterans Affairs is authorized to carry out administrative reorganization of the Department and change certain procedures used in VA medical centers to facilitate their operation as health plans.

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM: SUMMARY OF TITLE VIII

The Federal Employees Health Benefits Program ends in the United States effective December 31, 1997. Federal employees enroll in regional alliances where they live and pay premiums, like all other American workers. The employer share of premium payments are paid from federal budget appropriations.

After the termination of FEHBP, individuals eligible for its coverage who live abroad continue to be eligible for health insurance under a program established by the Office of Personnel Management. Coverage and benefits reflect the level of benefits available to individuals in the United States to the extent practicable.

The Office of Personnel Management may, on the request of an annuitant (federal retiree) enrolled in a health plan, withhold from an annuity any premium payments required. In the case of an annuitant whose liability to the regional alliance is not reduced by employer premium payments, a Government contribution reduces the employee's liability to zero.

Office of Personnel Management may offer one or more FEHBP supplemental plans and Medicare Supplemental plans. Each annuitant who was an annuitant or eligible family member of an annuitant on December 31, 1997 is eligible for Government contributions toward a supplemental plan.

Government contributions are paid from annual appropriations for that purpose. Contributions related to any supplemental plans, including Medicare supplemental plans, or policies covering individuals eligible for FEHBP who live abroad, are paid into a fund established in the United States Treasury.

Retired employees who would have been eligible for coverage under the Retired Federal Employees Health Benefits Act are treated as if they were annuitants.

EMPLOYEES HEALTH BENEFITS FUND

Amounts in the Employees Health Benefits Fund remain available after the termination of FEHBP to satisfy any outstanding claims. When all claims are resolved, any amounts remaining in the Fund are disbursed between the Government and former participants in FEHBP under a plan prepared by the Office of Personnel Management, consistent with the cost sharing ratio between the Government and current enrollees. The details of the plan must be submitted to the President and Congress at least a year before implementation.

The Retired Federal Employees Health Benefits Act is repealed effective on the same date that FEHBP ends. It remains available temporarily and is then disbursed in the same manner as the Employees Health Benefits Fund.

INDIAN HEALTH SERVICES: TITLE VIII

An eligible individual may enroll in a health program of the Indian Health Service instead of a health plan offered through a regional alliance if the individual is:

- An Indian or a descendent of a member of an Indian tribe who belongs to and is regarded as an Indian by the community in which the individual lives who resides on or near an Indian reservation.

- An urban Indian.

- An Indian living in certain counties in California as described in the Indian Health Care Improvement Act.

An individual who elects a health program of the Indian Health Service is not required to pay health insurance premiums or other cost sharing. If an individual chooses not to enroll in a health program of the Indian Health Service, the Indian Health Service does not pay the premiums and cost sharing required by another health plan.

Tribal governments and tribal organizations under the Indian Self–Determination and Educational Assistance Act or a self–governance compact are not required to make employer premium payments.

Funds appropriated to the Indian Health Service for supplemental benefits are: $180 million for fiscal year 1995 and $200 million for each fiscal year from 1996 through 1999.

Beginning on January 1, 1999, all health programs of the Indian Health Service provide the nationally guaranteed comprehensive benefit package. The Secretary may expend funds and provide loans for the construction and renovation of hospitals, health centers and other facilities in order to deliver the nationally guaranteed comprehensive benefit package.

A program or facility of the Indian Health Service may contract with a health plan to provide services to enrolled individuals if the contract will not result in a denial or diminution of services to Indians enrolled in a Indian Health Service. The health program or faculty is reimbursed as an essential community provider.

A health program of the Indian Health Service may open enrollment to family members of eligible individuals. If it does, family members who choose to obtain care through the Indian Health Service pay premiums and cost sharing and are eligible for premium discounts under the same rules as apply in other health plans.

If a health program or facility of the Indian Health Service elects to act as an essential community provider, an eligible individual or family member may receive health services from the essential community provider.

The Secretary must consult with representatives of Indian tribes, tribal organizations and urban Indian organizations annually concerning health care reform initiatives that affect Indian communities.

To carry out the program outlined here, the Indian Health Service receives appropriations of $40 million for fiscal year 1995, $180 million for fiscal year 1996 and $200 million for each fiscal year between 1997 and 2000.

VIII. MANAGING TRANSITION TO REFORM

COORDINATION OF MEDICAL PORTION OF WORKER'S COMPENSATION AND AUTOMOBILE INSURANCE

OVERVIEW

To achieve greater simplicity and efficiency, health plans consolidate services for individuals covered under workers' compensation insurance and automobile insurance, providing medical care through one insurance policy.

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

Health plans also demonstrate their ability to provide or arrange for additional medical benefits required for severe automobile injuries such as long-term rehabilitation and long-term care.

Health plans are paid by workers' compensation and automobile insurance carriers for the cost of care. Financing continues to be handled separately, although the delivery of service is integrated.

COORDINATION OF MEDICAL PORTION OF WORKERS' COMPENSATION AND AUTOMOBILE INSURANCE: SUMMARY OF TITLE X

Each health plan provides or arranges services covered under workers' compensation insurance for its participants. Health plans may provide services through:

- A participating provider.
- Another provider with whom the plan enters into an agreement for services.
- A specialized workers' compensation provider.

Individuals entitled to workers' compensation medical benefits generally receive services through the health plan in which they are enrolled, except for emergency services and services for certain veterans, active-duty military personnel and individuals eligible for the Indian Health Services.

Each health plan employs or enters into a contract with individuals experienced in the treatment of occupational illness and injury who provide case management for injured workers. The case manager is responsible for ensuring that a plan of treatment for each

injured worker assures appropriate care and facilitates return to work and compliance with legal requirements under State law. The case manager also coordinates care between the insurance carrier and the employer.

PAYMENT BY WORKERS' COMPENSATION CARRIER

Workers' compensation carriers pay for health services provided to injured workers according to regional alliance fee schedules. An alliance or State may establish an alternative payment method, such as payment of a negotiated fee, or the insurance carrier and health plan may negotiate alternative payment arrangements.

An injured worker may not be required to make any payment, including cost sharing, of any amount in excess of the applicable fee to any health plan or provider for services covered under workers' compensation.

Each participating State develops a fee schedule for specialized workers' compensation services not included in the standard regional alliance fee schedule and coordinates access to specialized providers on behalf of health plans.

States may designate specialized workers' compensation providers to deliver services not included in the nationally guaranteed comprehensive benefit, such as specialized occupational or rehabilitative services.

PREEMPTION OF STATE LAWS RESTRICTING DELIVERY OF BENEFITS.

No State law may restrict the choice or payment of providers who deliver health services to injured workers. However, State law may establish a method for resolving disputes related to:

- An individual's entitlement to workers' compensation medical benefits.
- The necessity and appropriateness of services provided to an injured worker.
- Charges or fees for workers' compensation services.

State laws continue to govern such issues as the determination of whether a person is entitled to workers' compensation benefits, the scope of items and services available to injured workers and the eligibility of any individual or group to workers' compensation medical benefits.

The Health Security Act does not prevent a State from integrating or otherwise coordinating payments for workers' compensation medical benefits with payment for health insurance or health benefit plans.

DEVELOPMENT OF PROTOCOLS AND CAPITATION PAYMENT MODELS

The Secretary of Health and Human Services and the Secretary of Labor develop protocols for the treatment of work-related conditions and may contract with one or more health alliances to test the validity of protocols.

Using the protocols, the Secretary of Health and Human Services and the Secretary of Labor develop a method for workers' compensation insurance carriers to pay health plans a fixed amount for the treatment of specific injuries and illnesses.

TRANSITIONAL INSURANCE REFORM: SUMMARY OF TITLE XI

OVERVIEW

The commitment to security for all Americans through universal health coverage demands an aggressive schedule of implementation. The far-reaching change required to implement reform while also controlling costs, demands gradual phasing in to ensure that the new system works reliably and produces the intended results.

The Health Security Act strikes a balance between prudence and the expeditious schedule demanded by the compelling need for health care reform. It proposes phasing in health reform over several years with each state choosing its own pace but implementing health reform by the end of 1997.

Under the proposed transition, states have flexibility to decide how rapidly they will move toward full implementation. They set their own pace, with incentives to move quickly, and support to ensure successful implementation.

Other aspects of comprehensive reform -- such as the expansion of home and community-based services for long-term care -- require longer implementation and are not fully implemented until the end of the decade.

During the transition, immediate reforms to the health insurance market remove some of the most egregious practices. Other immediate steps protect consumers from potential disruptions in coverage if health insurers choose to leave the market or attempt to exploit the transition.

While the schedule for implementation is aggressive, the design of health reform allows ample latitude for mid-course correction. The phasing in of new funding, new benefits and new programs could be extended. For example, national targets for slowing the rate of growth in health care spending could be adjusted.

Although the implementation of national health security is paramount among the goals of national reform, taking care to avoid unnecessary disruption to consumers, patients and health care providers stands as an equal goal.

TRANSITIONAL INSURANCE REFORM: SUMMARY OF TITLE XI

To expedite implementation, the National Health Board, the Department of Labor and the Department of Health and Human Services are authorized to issue regulations required under the Health Security Act on an interim and final basis.

To reduce the potential for disruption in the health insurance industry during the transition to reform, the Health Security Act imposes interim insurance regulations.

States enforce the regulations. The Department of Health and Human Services enforces them if states failed to do so.

Partially self-funded groups, self-funded multiple employer welfare arrangements (MEWA's), HMOs and other health plans are subject to the same regulatory requirements as insurers.

REQUIREMENTS TO KEEP COVERAGE IN FORCE

Insurers are prohibited from terminating or failing to renew health insurance coverage for any insured person, except for non-payment of premiums, fraud, or misrepresentation of a fact relating to an application for coverage or claim for benefits.

Insurers are required to accept all newly hired, full-time employees and dependents added to groups that are currently insured. Rates charged coincide with rates established according to a state-approved rate table.

RESTRICTIONS ON PREMIUM INCREASES

Premium increases during the transition to health reform are subject to the following requirements:

- Each insurer divides its business in each state into three sectors for the purpose of calculating rate increases.
  - Individual contracts.
  - Contracts covering groups with 100 or less participants.
  - Contracts covering larger groups with over 100 participants.
- Any increases in premium rates must apply equally to all covered groups and individuals:
  - All small groups and individuals receive the same percentage increase in rates.
  - For large groups, a portion of any increase could be based on group credibility as long as the total average increase equals the increase charged to individuals and small groups.

To address changes in group composition, each insurer is required to develop a single rate manual for each segment of its market. Base rates are fixed at the average costs in each segment.

Changes in premium rates for groups due to changes in the demographic composition of the group are calculated from the manual. New additions to groups and groups applying for new coverage are accepted at rates established in the manual.

States with existing statutes reforming the market for health insurance may modify rules related to premium increases to accommodate the goal of rate compression. The Department of Health and Human Services, in consultation with states (e.g. the National Association of Insurance Commissioners), issues guidelines for state modifications.

Premium increases that exceed a prescribed percentage are subject to prior approval by state insurance regulators. An administrative process provides a channel for appeal by insurers.

PORTABILITY

To increase portability of coverage during the transition to the new health insurance system:

- Insurers and self-insured employer plans are prohibited from applying exclusions for pre-existing medical conditions to new employees and their dependents who were insured prior to current employment.

  For new employees and their dependents previously not insured, exclusions for pre-existing conditions may not extend beyond six months.

- Self-funded health plans and employers with insured health plans are prohibited from imposing waiting periods for coverage on any employee otherwise eligible under the terms of the plan.

REDUCTIONS IN BENEFITS

To ensure that employers and insurers do not impose caps or exclusions on coverage for specific medical conditions during the transition, employers and insurers are prohibited from reducing existing coverage for any medical condition or course of treatment if the anticipated cost is likely to exceed $5,000 in a year.

As under current law, employers may impose overall caps or reduce coverage as long as these changes are applied equally to all participants in a health plan.

ACCESS TO COVERAGE

To assure that health insurance is available during the transition for individuals who lose coverage or are unable to obtain coverage because of health status, the Secretary of Health and Human Services may organize a national risk pool.

The Department of Health and Human Services administers the pool which contracts with one or more private insurance firms to act as its intermediaries and administrative agents.

The risk pool provides coverage to any uninsured person or group unable to obtain coverage in the private insurance market. Premiums, benefits and terms of coverage are set in a manner similar to existing state high risk pool.

Because the pool is voluntary, it operates under traditional insurance rating methods. Premiums vary according to age, gender and place of residence.

Premiums and assessments against all insurers support the pool, with assessments calculated based on market share in the health insurance market. Self-funded health plans also contribute to the pool through an assessment.

If premiums are not sufficient to pay claims incurred by the pool, additional assessments against insurers and self-funded health plans make up the difference.

The pool reimburses providers who treat participants based on Medicare payment rates; providers may not bill patients for the balance of any fee covered under the pool.

The Department of Health and Human Services may enter into contracts with risk pools in states to administer the federal pool.